research, the research shall first be reviewed and approved by an IRB, as provided in this policy, a certification submitted, by the institution, to the department or agency, and final approval given to the proposed change by the department or agency.

**§ 16.120 Evaluation and disposition of applications and proposals for research to be conducted or supported by a Federal Department or Agency.**

(a) The department or agency head will evaluate all applications and proposals involving human subjects submitted to the department or agency through such officers and employees of the department or agency and such experts and consultants as the department or agency head determines to be appropriate. This evaluation will take into consideration the risks to the subjects, the adequacy of protection against these risks, the potential benefits of the research to the subjects and others, and the importance of the knowledge gained or to be gained.

(b) On the basis of this evaluation, the department or agency head may approve or disapprove the application or proposal, or enter into negotiations to develop an approvable one.

**§ 16.121 [Reserved]**

**§ 16.122 Use of Federal funds.**

Federal funds administered by a department or agency may not be expended for research involving human subjects unless the requirements of this policy have been satisfied.

**§ 16.123 Early termination of research support: Evaluation of applications and proposals.**

(a) The department or agency head may require that department or agency support for any project be terminated or suspended in the manner prescribed in applicable program requirements, when the department or agency head finds an institution has materially failed to comply with the terms of this policy.

(b) In making decisions about supporting or approving applications or proposals covered by this policy the department or agency head may take into account, in addition to all other eligibility requirements and program criteria, factors such as whether the applicant has been subject to a termination or suspension under paragarph (a) of this section and whether the applicant or the person or persons who would direct or has have directed the scientific and technical aspects of an activity has have, in the judgment of the department or agency head, materially failed to discharge responsibility for the protection of the rights and welfare of human subjects (whether or not the research was subject to federal regulation).

**§ 16.124 Conditions.**

With respect to any research project or any class of research projects the department or agency head may impose additional conditions prior to or at the time of approval when in the judgment of the department or agency head additional conditions are necessary for the protection of human subjects.

# PART 17—MEDICAL

DEFINITIONS AND ACTIVE DUTY

Sec.



PROTECTION OF PATIENT RIGHTS



TENTATIVE ELIGIBILITY DETERMINATIONS



HOSPITAL OR NURSING HOME CARE AND MEDICAL SERVICES IN FOREIGN COUNTRIES



ENROLLMENT PROVISIONS AND MEDICAL BENEFITS PACKAGE



EXAMINATIONS AND OBSERVATION AND EXAMINATION

AUTHORITY: 38 U.S.C. 501, 1721, unless otherwise noted.

EDITORIAL NOTE: Nomenclature changes to part 17 appear at 61 FR 7216, Feb. 27, 1996.

DEFINITIONS AND ACTIVE DUTY

## § 17.30 Definitions.

When used in Department of Veterans Affairs medical regulations, each of the following terms shall have the meaning ascribed to it in this section:

(a) *Medical services.* The term *medical services* includes, in addition to medical examination, treatment, and rehabilitative services:

(1) Surgical services, dental services and appliances as authorized in §§ 17.160 through 17.166, optometric and podiatric services, (in the case of a person otherwise receiving care or services under this chapter) the preventive health care services set forth in 38 U.S.C. 1762, wheelchairs, artificial limbs, trusses and similar appliances, special clothing made necessary by the wearing of prosthetic appliances, and such other supplies or services as are medically determined to be reasonable and necessary.

(Authority: 38 U.S.C. 1701(6)(A)(i))

(2) Such consultation, professional counseling, training and mental health services as are necessary in connection with the treatment—

(i) Of the service-connected disability of a veteran pursuant to § 17.93(a);

(ii) Of the nonservice-connected disability of a veteran where such services were initiated during the veteran's hospitalization and the provision of such services is essential to permit the release of the veteran from inpatient care;

for the members of the immediate family or legal guardian of the veteran, or the individual in whose household such veteran certifies an intention to live, as may be essential to the effective treatment and rehabilitation of the veteran or dependent or survivor of a veteran receiving care under § 17.84(c). For the purposes of this paragraph, a dependent or survivor of a veteran receiving care under § 17.84(c) shall be eligible for the same medical services as a veteran; and

(3) Transportation and incidental expenses for any person entitled to such benefits under the provisions of § 17.143.

(Authority: 38 U.S.C. 1701(6))

(b) *Domiciliary care.* The term *domiciliary care* means the furnishing of a home to a veteran, embracing the furnishing of shelter, food, clothing and other comforts of home, including necessary medical services. The term further includes travel and incidental expenses pursuant to § 17.143.

(Authority: 38 U.S.C. 1701(4))

[23 FR 6498, Aug. 22, 1958, as amended at 24 FR 8326, Oct. 14, 1959; 30 FR 1787, Feb. 9, 1965; 32 FR 6841, Mar. 4, 1967; 32 FR 13813, Oct. 4, 1967; 33 FR 5298, Apr. 3, 1968; 33 FR 19009, Dec. 20, 1968; 34 FR 9339, June 13, 1969; 36 FR 4782, Mar. 12, 1971; 45 FR 6934, Jan. 31, 1980; 47 FR 58246, Dec. 30, 1982; 49 FR 50029, Dec. 26, 1984; 51 FR 25264, July 10, 1986; 54 FR 14648, Apr. 12, 1989; 61 FR 21965, 21966, May 13, 1996; 62 FR 17072, Apr. 9, 1997]

### § 17.31 Duty periods defined.

Definitions of duty periods applicable to eligibility for medical benefits are as follows:

(a)—(c) [Reserved]

(d) *Inactive duty training.* The term *inactive duty training* means: (1) Duty (other than full-time duty) prescribed for Reserves (including commissioned officers of the Reserve Corps of the Public Health Service) by the Secretary concerned under section 206, title 37 U.S.C., or any other provision of law;

(2) Special additional duties authorized for Reserves (including commissioned officers of the Reserve Corps of the Public Health Service) by an authority designated by the Secretary concerned and performed by them on a voluntary basis in connection with the prescribed training or maintenance activities of the units to which they are assigned.

(3) Duty (other than full-time duty) for members of the National Guard or Air National Guard of any State under the provisions of law stated in paragraph (c)(3) of this section.

(4) Inactive duty for training does not include work or study performed in connection with correspondence courses, or attendance at an educational institution in an inactive status, or duty performed as a temporary member of the Coast Guard Reserve.

[34 FR 9339, June 13, 1969, as amended at 45 FR 6934, Jan. 31, 1980; 45 FR 43169, June 26, 1980; 48 FR 56580, Dec. 22, 1983; 61 FR 21965, May 13, 1996]

EDITORIAL NOTE: At 61 FR 21965, May 13, 1996, § 17.31 was amended by removing (a), (b) introductory text, (b)(1) through (b)(4), (b)(6), (b)(7) and (c). Text remaining in effect is set forth above.

### § 17.31 Duty periods defined.

Full-time duty as a member of the Women's Army Auxiliary Corps, Women's Reserve of the Navy and Marine Corps and Women's Reserve of the Coast Guard.

[34 FR 9339, June 13, 1969, as amended at 61 FR 21965, May 13, 1996]

EDITORIAL NOTE: At 61 FR 21965, May 13, 1996, § 17.31(b)(5) was redesignated as § 17.31.

## PROTECTION OF PATIENT RIGHTS

### § 17.32 Informed consent.

(a) *Definitions*:

*Close friend.* Any person eighteen years or older who has shown care and concern for the patient's welfare, who is familiar with the patient's activities, health, religious beliefs and values, and who has presented a signed written statement for the record that describes that person's relationship to and familiarity with the patient.

*Decision-making capacity.* The ability to understand and appreciate the nature and consequences of health-care treatment decisions.

*Health-care agent.* An individual named by the patient in a Durable Power of Attorney for Health Care.

*Legal guardian.* A person appointed by a court of appropriate jurisdiction to make decisions for an individual who has been judicially determined to be incompetent.

*Practitioner.* Any physician, dentist, or health-care professional who has been granted specific clinical privileges to perform the treatment or procedure involved. For the purpose of obtaining informed consent for medical treatment, the term practitioner includes medical and dental residents regardless of whether they have been granted clinical privileges.

*Signature consent.* The patient's or surrogate's signature on a VA-authorized consent form, *e.g.*, a published numbered VA form (OF 522) or comparable form approved by the local VA facility.

*Special guardian.* A person appointed by a court of appropriate jurisdiction for the specific purpose of making health-care decisions.

*Surrogate.* An individual, organization or other body authorized under this section to give informed consent on behalf of a patient who lacks decision-making capacity.

(b) *Policy.* Except as otherwise provided in this section, all patient care furnished under title 38 U.S.C. shall be carried out only with the full and informed consent of the patient or, in appropriate cases, a representative thereof. In order to give informed consent, the patient must have decision-making capacity and be able to communicate decisions concerning health care. If the patient lacks decision-making capacity or has been declared incompetent, consent must be obtained from the patient's surrogate. Practitioners may provide necessary medical care in emergency situations without the patient's or surrogate's express consent when immediate medical care is necessary to preserve life or prevent serious impairment of the health of the patient or others and the patient is unable to consent and the practitioner determines that the patient has no surrogate or that waiting to obtain consent from the patient's surrogate would increase the hazard to the life or health of the patient or others. In such circumstances consent is implied.

(c) *General requirements for informed consent.* Informed consent is the freely given consent that follows a careful explanation by the practitioner to the patient or the patient's surrogate of the proposed diagnostic or therapeutic procedure or course of treatment. The practitioner, who has primary responsibility for the patient or who will perform the particular procedure or provide the treatment, must explain in language understandable to the patient or surrogate the nature of a proposed procedure or treatment; the expected benefits; reasonably foreseeable associated risks, complications or side effects; reasonable and available alternatives; and anticipated results if nothing is done. The patient or surrogate must be given the opportunity to ask questions, to indicate comprehension of the information provided, and to grant permission freely without coercion. The practitioner must advise the patient or surrogate if the proposed treatment is novel or unorthodox. The patient or surrogate may withhold or revoke his or her consent at any time.

(d) *Documentation of informed consent.* (1) The informed consent process must be appropriately documented in the medical record. In addition, signature consent is required for all diagnostic and therapeutic treatments or procedures that:

(i) Require the use of sedation;

(ii) Require anesthesia or narcotic analgesia;

(iii) Are considered to produce significant discomfort to the patient;

(iv) Have a significant risk of complication or morbidity;

(v) Require injections of any substance into a joint space or body cavity; or

(vi) Involve testing for Human Immunodeficiency Virus (HIV).

(2) The patient's or surrogate's signature on a VA-authorized consent form must be witnessed. The witness' signature only attests to the fact that he or she saw the patient or surrogate and the practitioner sign the form. When the patient's or surrogate's signature is indicated by an ''X'', two adults must witness the act of signing. The signed form must be filed in the patient's medical record. A properly executed OF 522 or other VA-authorized consent form is valid for a period of 30 calendar days. If, however, the treatment plan involves multiple treatments or procedures, it will not be necessary to repeat the informed consent discussion and documentation so long as the course of treatment proceeds as planned, even if treatment extends beyond the 30-day period. If there is a change in the patient's condition that might alter the diagnostic or therapeutic decision, the consent is automatically rescinded.

(3) If it is impractical to consult with the surrogate in person, informed consent may be obtained by mail, facsimile, or telephone. A facsimile copy of a signed consent form is adequate to proceed with treatment. However, the surrogate must agree to submit a signed consent form to the practitioner. If consent is obtained by telephone, the conversation must be audiotaped or witnessed by a second VA employee. The name of the person giving consent and his or her authority to act as surrogate must be adequately identified for the record.

(e) *Surrogate consent.* If the practitioner who has primary responsibility for the patient determines that the patient lacks decision-making capacity and is unlikely to regain it within a reasonable period of time, informed consent must be obtained from the patient's surrogate. Patients who are incapable of giving consent as a matter of law, i.e., persons judicially determined to be incompetent and minors not otherwise able to provide informed consent, will be deemed to lack decision-making capacity for the purposes of this section. If the patient is considered a minor in the state where the VA facility is located and cannot consent to medical treatment, consent must be obtained from the patient's parent or legal guardian. The surrogate generally assumes the same rights and responsibilities as the patient in the informed consent process. The surrogate's decision must be based on his or her knowledge of what the patient would have wanted, *i.e.,* substituted judgment. If the patient's wishes are unknown, the decision must be based on the patient's best interest. The following persons are authorized to consent on behalf of patients who lack decision-making capacity in the following order of priority:

(1) Health-care agent;

(2) Legal guardian or special guardian;

(3) Next-of-kin: a close relative of the patient eighteen years of age or older, in the following priority: spouse, child, parent, sibling, grandparent, or grandchild; or

(4) Close friend.

(f) *Consent for patients without surrogates.* (1) If none of the surrogates listed in paragraph (e) of this section are available, the practitioner may request Regional Counsel assistance to obtain a special guardian for health care or follow the procedures outlined in this paragraph (f).

(2) Facilities may use the following process to make treatment decisions for patients who lack decision-making capacity and have no surrogate. For treatments or procedures that involve minimal risk, the practitioner must verify that no authorized surrogate can be located. The practitioner must attempt to explain the nature and purpose of the proposed treatment to the patient and enter this information in the medical record. For procedures that require signature consent, the practitioner must certify that the patient has no surrogate. The attending physician and the Chief of Service (or his or her designee) must indicate their approval of the treatment decision in writing. Any decision to withhold or withdraw life-sustaining treatment for such patients must be reviewed by a multi-disciplinary committee appointed by the facility Director. The committee functions as the patient's advocate and may not include members of the treatment team. The committee must submit its findings and recommendations in a written report to the Chief of Staff who must note his or her approval of the report in writing. After reviewing the record, the facility Director may concur with the decision to withhold or withdraw life support or request further review by Regional Counsel.

(g) *Special consent situations.* In addition to the other requirements of this section, additional protections are required in the following situations.

(1) No patient will undergo any unusual or extremely hazardous treatment or procedure, *e.g.,* that which might result in irreversible brain damage or sterilization, except as provided in this paragraph (g). Before treatment is initiated, the patient or surrogate must be given adequate opportunity to consult with independent specialists, legal counsel or other interested parties of his or her choosing. The patient's or surrogate's signature on a VA authorized consent form must be witnessed by someone who is not affiliated with the VA health-care facility,

*e.g.*, spouse, legal guardian, or patient advocate. If a surrogate makes the treatment decision, a multi-disciplinary committee, appointed by the facility Director, must review that decision to ensure it is consistent with the patient's wishes or in his or her best interest. The committee functions as the patient's advocate and may not include members of the treatment team. The committee must submit its findings and recommendations in a written report to the facility Director. The Director may authorize treatment consistent with the surrogate's decision or request that a special guardian for health care be appointed to make the treatment decision.

(2) Administration of psychotropic medication to an involuntarily committed patient against his or her will must meet the following requirements. The patient or surrogate must be allowed to consult with independent specialists, legal counsel or other interested parties concerning the treatment with psychotropic medication. Any recommendation to administer or continue medication against the patient's or surrogate's will must be reviewed by a multi-disciplinary committee appointed by the facility Director for this purpose. This committee must include a psychiatrist or a physician who has psychopharmacology privileges. The facility Director must concur with the committee's recommendation to administer psychotropic medications contrary to the patient's or surrogate's wishes. Continued therapy with psychotropic medication must be reviewed every 30 days. The patient (or a representative on the patient's behalf) may appeal the treatment decision to a court of appropriate jurisdiction.

(3) If a proposed course of treatment or procedure involves approved medical research in whole or in part, the patient or representative shall be advised of this. Informed consent shall be obtained specifically for the administration or performance of that aspect of the treatment or procedure that involves research. Such consent shall be in addition to that obtained for the administration or performance of the nonresearch aspect of the treatment or procedure and must meet the requirements for informed consent set forth in 38 CFR Part 16, *Protection of Human Subjects.*

(4) Testing for Human Immunodeficiency Virus (HIV) must be voluntary and must be conducted only with the prior informed and (written) signature consent of the patient or surrogate. Patients who consent to testing for HIV must sign VA form 10–012, ''Consent for HIV Antibody Testing.'' This form must be filed in the patient's medical record. Testing must be accompanied by pre-test and post-test counseling.

(The information collection requirements in this section have been approved by the Office of Management and Budget under control number 2900–0583)

(Authority: 38 U.S.C. 7331, 7332, 7333)

[62 FR 53961, Oct. 17, 1997]

### § 17.33 Patients' rights.

(a) *General.* (1) Patients have a right to be treated with dignity in a humane environment that affords them both reasonable protection from harm and appropriate privacy with regard to their personal needs.

(2) Patients have a right to receive, to the extent of eligibility therefor under the law, prompt and appropriate treatment for any physical or emotional disability.

(3) Patients have the right to the least restrictive conditions necessary to achieve treatment purposes.

(4) No patient in the Department of Veterans Affairs medical care system, except as otherwise provided by the applicable State law, shall be denied legal rights solely by virtue of being voluntarily admitted or involuntarily committed. Such legal rights include, but are not limited to, the following:

(i) The right to hold and to dispose of property except as may be limited in accordance with paragraph (c)(2) of this section;

(ii) The right to execute legal instruments (e.g., will);

(iii) The right to enter into contractual relationships;

(iv) The right to register and vote;

(v) The right to marry and to obtain a separation, divorce, or annulment;

(vi) The right to hold a professional, occupational, or vehicle operator's license.

(b) *Residents and inpatients.* Subject to paragraph (c) of this section, patients admitted on a residential or inpatient care basis to the Department of Veterans Affairs medical care system have the following rights:

(1) *Visitations and communications.* Each patient has the right to communicate freely and privately with persons outside the facility, including government officials, attorneys, and clergymen. To facilitate these communications each patient shall be provided the opportunity to meet with visitors during regularly scheduled visiting hours, convenient and reasonable access to public telephones for making and receiving phone calls, and the opportunity to send and receive unopened mail.

(i) Communications with attorneys, law enforcement agencies, or government officials and representatives of recognized service organizations when the latter are acting as agents for the patient in a matter concerning Department of Veterans Affairs benfits, shall not be reviewed.

(ii) A patient may refuse visitors.

(iii) If a patient's right to receive unopened mail is restricted pursuant to paragraph (c) of this section, the patient shall be required to open the sealed mail while in the presence of an appropriate person for the sole purpose of ascertaining whether the mail contains contraband material, i.e., implements which pose significant risk of bodily harm to the patient or others or any drugs or medication. Any such material will be held for the patient or disposed of in accordance with instructions concerning patients' mail published by the Veterans Health Administration, Department of Veterans Affairs, and/or the local health care facility.

(iv) Each patient shall be afforded the opportunity to purchase, at the patient's expense, letter writing material including stamps. In the event a patient needs assistance in purchasing writing material, or in writing, reading or sending mail, the medical facility will attempt, at the patient's request, to provide such assistance by means of volunteers, sufficient to mail at least one (1) letter each week.

(v) All information gained by staff personnel of a medical facility during the course of assisting a patient in writing, reading, or sending mail is to be kept strictly confidential except for any disclosure required by law.

(2) *Clothing.* Each patient has the right to wear his or her own clothing.

(3) *Personal Possessions.* Each patient has the right to keep and use his or her own personal possessions consistent with available space, governing fire safety regulations, restrictions on noise, and restrictions on possession of contraband material, drugs and medications.

(4) *Money.* Each patient has the right to keep and spend his or her own money and to have access to funds in his or her account in accordance with instructions concerning personal funds of patients published by the Veterans Health Administration.

(5) *Social Interaction.* Each patient has the right to social interaction with others.

(6) *Exercise.* Each patient has the right to regular physical exercise and to be outdoors at regular and frequent intervals. Facilities and equipment for such exercise shall be provided.

(7) *Worship.* The opportunity for religious worship shall be made available to each patient who desires such opportunity. No patient will be coerced into engaging in any religious activities against his or her desires.

(c) *Restrictions.* (1) A right set forth in paragraph (b) of this section may be restricted within the patient's treatment plan by written order signed by the appropriate health or mental health professional if—

(i) It is determined pursuant to paragraph (c)(2) of this section that a valid and sufficient reason exists for a restriction, and

(ii) The order imposing the restriction and a progress note detaining the indications therefor are both entered into the patient's permanent medical record.

(2) For the purpose of this paragraph, a valid and sufficient reason exists when, after consideration of pertinent facts, including the patient's history, current condition and prognosis, a health or mental health professional

reasonably believes that the full exercise of the specific right would—

(i) Adversely affect the patient's physical or mental health,

(ii) Under prevailing community standards, likely stigmatize the patient's reputation to a degree that would adversely affect the patient's return to independent living,

(iii) Significantly infringe upon the rights of or jeopardize the health or safety of others, or

(iv) Have a significant adverse impact on the operation of the medical facility, to such an extent that the patient's exercise of the specific right should be restricted. In determining whether a patient's specific right should be restricted, the health or mental health professional concerned must determine that the likelihood and seriousness of the consequences that are expected to result from the full exercise of the right are so compelling as to warrant the restriction. The Chief of Service or Chief of Staff, as designated by local policy, should concur with the decision to impose such restriction. In this connection, it should be noted that there is no intention to imply that each of the reasons specified in paragraphs (c)(2)(i) through (iv) of this section are logically relevant to each of the rights set forth in paragraph (b)(1) of this section.

(3) If it has been determined under paragraph (c)(2) of this section that a valid and sufficient reason exists for restricting any of the patient's rights set forth in paragraph (c)(1) of this section, the least restrictive method for protecting the interest or interests specified in paragraphs (c)(2)(i) through (iv) of this section that are involved shall be employed.

(4) The patient must be promptly notified of any restriction imposed pursuant to this paragraph and the reasons therefor.

(5) All restricting orders must be reviewed at least once every 30 days by the practitioner and must be concurred in by the Chief of Service or Chief of Staff.

(d) *Restraint and seclusion of patients.* (1) Each patient has the right to be free from physical restraint or seclusion except in situations in which there is a substantial risk of imminent harm by the patient to himself, herself, or others and less restrictive means of preventing such harm have been determined to be inappropriate or insufficient. Patients will be physically restrained or placed in seclusion only on the written order of a physician. The reason for any restraint order will be clearly documented in the progress notes of the patient's medical record. The written order may be entered on the basis of telephonic authority received from a physician, but in such an event the ordering physician must examine the patient and sign the written order within twelve (12) hours of giving the order for restraint or seclusion. In emergency situations, where inability to contact a physician prior to restraint is likely to result in immediate harm to the patient or others, the patient may be temporarily restrained by a member of the staff until appropriate authorization can be received from a physician. Use of restraints or seclusion shall be for no more than twenty-four (24) hours, at which time the physician shall again be consulted to determine if continuance of such restraint or seclusion is required. Restraint or seclusion may not be used as a punishment, for the convenience of staff, or as a substitute for treatment programs.

(2) While in restraint or seclusion, the patient must be seen at least once every twelve (12) hours by an appropriate health professional who will monitor and chart the patient's physical and mental condition and by other ward personnel as frequently as is reasonable under existing circumstances, but no less than once each hour.

(3) Each patient in restraint or seclusion shall have bathroom privileges according to his or her needs.

(4) Each patient in restraint or seclusion shall have the opportunity to bathe at least every twenty-four (24) hours.

(5) Each patient in restraint or seclusion shall be provided nutrition and fluid appropriately.

(e) *Medication.* Patients have a right to be free from unnecessary or excessive medication. Except in an emergency, medication will be administered only on the written order of a physician in that patient's medical record.

The written order may be entered on the basis of telephonic authority received from a physician, but in such event a physician must countersign the written order within 24 hours of the ordering of the medication. The attending physician shall be responsible for all medication given or administered to a patient. The attending physician shall review the drug regimen of each patient under his or her care at least every thirty (30) days. It is recognized that administration of certain medications will be reviewed more frequently. Medication shall not be used as punishment, for the convenience of the staff, or in quantities which interfere with the patient's treatment program.

(f) *Confidentiality*. Information gained by staff from the patient or the patient's medical record will be kept confidential and will not be disclosed except in accordance with applicable law.

(g) *Patient grievances.* Each patient has the right to present grievances with respect to perceived infringement of the rights described in this section or concerning any other matter on behalf of himself, herself or others, to staff members at the facility in which the patient is receiving care, other Department of Veterans Affairs officials, government officials, members of Congress or any other person without fear or reprisal.

(h) *Notice of patient's rights.* Upon the admission of any patient, the patient or his/her representative shall be informed of the rights described in this section, shall be given a copy of a statement of those rights and shall be informed of the fact that the statement of rights is posted at each nursing station. All staff members assigned to work with patients will be given a copy of the statement of rights and these rights will be discussed with them by their immediate supervisor.

(i) *Other rights.* The rights described in this section are in addition to and not in derogation of any statutory, constitutional or other legal rights.

(Authority: 38 U.S.C. 501, 1721)

[47 FR 55486, Dec. 10, 1982. Redesignated at 61 FR 21965, May 13, 1996]

TENTATIVE ELIGIBILITY DETERMINATIONS

### § 17.34 Tentative eligibility determinations.

Subject to the provisions of §§17.36 through 17.38, when an application for hospital care or other medical services, except outpatient dental care, has been filed which requires an adjudication as to service connection or a determination as to any other eligibility prerequisite which cannot immediately be established, the service (including transportation) may be authorized without further delay if it is determined that eligibility for care probably will be established. Tentative eligibility determinations under this section, however, will only be made if:

(a) *In emergencies.* The applicant needs hospital care or other medical services in emergency circumstances, or

(b) *For persons recently discharged from service.* The application was filed within 6 months after date of honorable discharge from a period of not less than 6 months of active duty.

[35 FR 6586, Apr. 24, 1970. Redesignated at 61 FR 21965, May 13, 1996, as amended at 64 FR 54212, Oct. 6, 1999]

HOSPITAL OR NURSING HOME CARE AND MEDICAL SERVICES IN FOREIGN COUNTRIES

### § 17.35 Hospital care and medical services in foreign countries.

The Secretary may furnish hospital care and medical services to any veteran sojourning or residing outside the United States, without regard to the veteran's citizenship:

(a) If necessary for treatment of a service-connected disability, or any disability associated with and held to be aggravating a service-connected disability;

(b) If the care is furnished to a veteran participating in a rehabilitation program under 38 U.S.C. chapter 31 who requires care for the reasons enumerated in 38 CFR 17.48(j)(2).

(Authority: 38 U.S.C. 1724)

[55 FR 11370, Mar. 28, 1990. Redesignated at 61 FR 21965, May 13, 1996]

ENROLLMENT PROVISIONS AND MEDICAL BENEFITS PACKAGE

### § 17.36 Enrollment—provision of hospital and outpatient care to veterans.

(a) *Enrollment requirement for veterans.* (1) Except as otherwise provided in § 17.37, a veteran must be enrolled in the VA healthcare system as a condition for receiving VA hospital and outpatient care.

NOTE TO PARAGRAPH (a)(1): A veteran may apply to be enrolled at any time. (See § 17.36(d)(1).)

(2) Except as provided in paragraph (a)(3) of this section, a veteran enrolled under this section is eligible for VA hospital and outpatient care as provided in the ''medical benefits package'' set forth in § 17.38.

NOTE TO PARAGRAPH (a)(2): A veteran's enrollment status will be recognized throughout the United States.

(3) A veteran enrolled based on having a disorder associated with exposure to a toxic substance or radiation, for a disorder associated with service in the Southwest Asia theater of operations during the Gulf War, or any illness associated with service in combat in a war after the Gulf War or during a period of hostility after November 11, 1998, as provided in 38 U.S.C. 1710(e), is eligible for VA hospital and outpatient care provided in the ''medical benefits package'' set forth in § 17.38 for the disorder.

(b) *Categories of veterans eligible to be enrolled.* The Secretary will determine which categories of veterans are eligible to be enrolled based on the following order of priority:

(1) Veterans with a singular or combined rating of 50 percent or greater based on one or more service-connected disabilities or unemployability.

(2) Veterans with a singular or combined rating of 30 percent or 40 percent based on one or more service-connected disabilities.

(3) Veterans who are former prisoners of war; veterans with a singular or combined rating of 10 percent or 20 percent based on one or more service-connected disabilities; veterans who were discharged or released from active military service for a disability incurred or aggravated in the line of duty; veterans who receive disability compensation under 38 U.S.C. 1151; veterans whose entitlement to disability compensation is suspended pursuant to 38 U.S.C. 1151, but only to the extent that such veterans' continuing eligibility for hospital and outpatient care is provided for in the judgment or settlement described in 38 U.S.C. 1151; veterans whose entitlement to disability compensation is suspended because of the receipt of military retired pay; and veterans receiving compensation at the 10 percent rating level based on multiple noncompensable service-connected disabilities that clearly interfere with normal employability.

(4) Veterans who receive increased pension based on their need for regular aid and attendance or by reason of being permanently housebound and other veterans who are determined to be catastrophically disabled by the Chief of Staff (or equivalent clinical official) at the VA facility where they were examined; except that a veteran who is catastrophically disabled and who must agree under 38 U.S.C. 1710 to pay to the United States a co-payment as condition of receiving VA care, must agree to pay to the United States the applicable co-payment to be enrolled in priority category 4.

(5) Veterans not covered by paragraphs (b)(1) through (b)(4) of this section who are determined to be unable to defray the expenses of necessary care under 38 U.S.C. 1722(a).

(6) Veterans of the Mexican border period or of World War I; veterans solely seeking care for a disorder associated with exposure to a toxic substance or radiation, for a disorder associated with service in the Southwest Asia theater of operations during the Gulf War, or for any illness associated with service in combat in a war after the Gulf War or during a period of hostility after November 11, 1998, as provided and limited in 38 U.S.C. 1710(e); and veterans with 0 percent service-connected disabilities who are nevertheless compensated, including veterans receiving compensation for inactive tuberculosis.

(7) Veterans who agree to pay to the United States the applicable copayment determined under 38 U.S.C. 1710(f)

and 1710(g). This category is further prioritized into the following subcategories:

(i) Noncompensable zero percent service-connected veterans; and

(ii) All other priority category 7 veterans.

(c) FEDERAL REGISTER *notification of eligible enrollees.* (1) It is anticipated that on or before August 1 of each year the Secretary will announce in paragraph (c)(2) of this section which categories of veterans are eligible to be enrolled. As necessary, the Secretary at any time may revise this determination by further amending paragraph (c)(2) of this section. The preamble to a FEDERAL REGISTER document announcing which priority categories are eligible to be enrolled must specify the projected number of fiscal year applicants for enrollment in each priority category, projected healthcare utilization and expenditures for veterans in each priority category, appropriated funds and other revenue projected to be available for fiscal year enrollees, and results—projected total expenditures for enrollees by priority category. The determination should include consideration of relevant internal and external factors, *e.g.*, economic changes, changes in medical practices, and waiting times to obtain an appointment for care. Consistent with these criteria, the Secretary will determine which categories of veterans are eligible to be enrolled based on the order of priority specified in paragraph (b) of this section.

(2) Unless changed by a rulemaking document in accordance with paragraph (c)(1) of this section, VA will enroll all priority categories of veterans set forth in §17.36(b) for the period from October 1, 1999 through September 30, 2000.

(d) *Enrollment and disenrollment process*—(1) *Application for enrollment.* A veteran may apply to be enrolled in the VA healthcare system at any time. A veteran who wishes to be enrolled must apply by submitting a VA Form 10–10EZ to a VA medical facility. Veterans applying based on inclusion in priority categories 1, 2, 3, 6, and 7 do not need to complete section II, but must complete the rest of the form. Veterans applying based on inclusion in priority category 4 because of their need for regular aid and attendance or by being permanently housebound need not complete section II, but must complete the rest of the form. Veterans applying based on inclusion in priority category 4 because they are catastrophically disabled need not complete section II, but must complete the rest of the form, if: they agree to pay to the United States the applicable copayment determined under 38 U.S.C. 1710(f) and 1710(g); they are a veteran of the Mexican border period or of World War I or a veteran with a 0 percent service-connected disability who is nevertheless compensated; their catastrophic disability is a disorder associated with exposure to a toxic substance or radiation, or with service in the Southwest Asia theater of operations during the Gulf War as provided in 38 U.S.C. 1710(e); or their catastrophic disability is an illness associated with service in combat in a war after the Gulf War or during a period of hostility after November 11, 1998, as provided in 38 U.S.C. 1710(e). All other veterans applying based on inclusion in priority category 4 because they are catastrophically disabled must complete the entire form. Veterans applying based on inclusion in priority category 5 must complete the entire form. VA Form 10–10EZ is set forth in paragraph (f) of this section and is available from VA medical facilities.

NOTE TO PARAGRAPH (d)(1): To remain enrolled based on inclusion in priority category 5, a veteran annually must return information to VA on a VA Form 10–10EZ as provided in paragraph (d)(4)(iii) of this section and otherwise meet the requirements for enrollment.

(2) *Action on application.* Upon receipt of a completed VA Form 10–10EZ, a VA network or facility director, or the Chief Network Officer, will accept a veteran as an enrollee upon determining that the veteran is in a priority category eligible to be enrolled as set forth in §17.36(c)(2). Upon determining that a veteran is not in a priority category eligible to be enrolled, the VA network or facility director, or the Chief Network Officer, will inform the applicant that the applicant is ineligible to be enrolled.

(3) *Automatic enrollment.* Notwithstanding other provisions of this section, veterans who were notified by VA letter that they were enrolled in the VA healthcare system under the trial VA enrollment program prior to October 1, 1998, automatically will be enrolled in the VA healthcare system under this section if determined by a VA network or facility director, or the Chief Network Officer, that the veteran is in a priority category eligible to be enrolled as set forth in §17.36(c)(2). Upon determining that a veteran is not in a priority category eligible to be enrolled, the VA network or facility director, or the Chief Network Officer, will inform the veteran that the veteran is ineligible to be enrolled.

(4) *Disenrollment.* A veteran enrolled under paragraph (d)(2) or (d)(3) of this section will be disenrolled only if:

(i) The veteran submits to a VA medical center a signed document stating that the veteran no longer wishes to be enrolled;

(ii) A VA network or facility director, or the Chief Network Officer, determines that the veteran is no longer in a priority category eligible to be enrolled, as set forth in §17.36(c)(2); or

(iii) A VA network or facility director, or the Chief Network Officer, determines that the veteran has been enrolled based on inclusion in priority category 5; determines that the veteran was sent by mail a VA Form 10–10EZ; and determines that the veteran failed to return the completed form to the address on the return envelope within 60 days from receipt of the form. VA Form 10–10EZ is set forth in paragraph (f) of this section.

(5) *Notification of enrollment status.* Notice of a decision by a VA network or facility director, or the Chief Network Officer, regarding enrollment status will be provided to the affected veteran by letter and will contain the reasons for the decision. The letter will include an effective date for any changes and a statement regarding appeal rights. The decision will be based on all information available to the decisionmaker, including the information contained in VA Form 10–10EZ.

(e) *Catastrophically disabled.* For purposes of this section, catastrophically disabled means to have a permanent severely disabling injury, disorder, or disease that compromises the ability to carry out the activities of daily living to such a degree that the individual requires personal or mechanical assistance to leave home or bed or requires constant supervision to avoid physical harm to self or others. This definition is met if an individual has been found by the Chief of Staff (or equivalent clinical official) at the VA facility where the individual was examined to have a permanent condition specified in paragraph (e)(1) of this section; to meet permanently one of the conditions specified in paragraph (e)(2) of this section by a clinical evaluation of the patient's medical records that documents that the patient previously met the permanent criteria and continues to meet such criteria (permanently) or would continue to meet such criteria (permanently) without the continuation of on-going treatment; or to meet permanently one of the conditions specified in paragraph (e)(2) of this section by a current medical examination that documents that the patient meets the permanent criteria and will continue to meet such criteria (permanently) or would continue to meet such criteria (permanently) without the continuation of on-going treatment.

(1) Quadriplegia and quadriparesis (ICD–9–CM Code 344.0x: 344.00, 344.01, 344.02, 344.03, 344.04, 3.44.09), paraplegia (ICD–9–CM Code 344.1), blindness (ICD–9–CM Code 369.4), persistent vegetative state (ICD–9–CM Code 780.03), or a condition resulting from two of the following procedures (ICD–9–CM Code 84.x or associated V Codes when available or Current Procedural Terminology (CPT) Codes) provided the two procedures were not on the same limb:

(i) Amputation through hand (ICD–9–CM Code 84.03 or V Code V49.63 or CPT Code 25927);

(ii) Disarticulation of wrist (ICD–9–CM Code 84.04 or V Code V49.64 or CPT Code 25920);

(iii) Amputation through forearm (ICD–9–CM Code 84.05 or V Code V49.65 or CPT Codes 25900, 25905);

(iv) Disarticulation of forearm (ICD–9–CM Code 84.05 or V Code V49.66 or CPT Codes 25900, 25905);

(v) Amputation or disarticulation through elbow. (ICD–9–CM Code 84.06 or V Code V49.66 or CPT 24999);

(vi) Amputation through humerus (ICD–9–CM Code 84.07 or V Code V49.66 or CPT Codes 24900, 24920);

(vii) Shoulder disarticulation (ICD–9–CM Code 84.08 or V Code V49.67 or CPT Code 23920);

(viii) Forequarter amputation (ICD–9–CM Code 84.09 or CPT Code 23900);

(ix) Lower limb amputation not otherwise specified (ICD–9–CM Code 84.10 or V Code V49.70 or CPT Codes 27880, 27882);

(x) Amputation of great toe (ICD–9–CM Code 84.11 or V Code V49.71 or CPT Codes 28810, 28820);

(xi) Amputation through foot (ICD–9–CM Code 84.12 or V Code V49.73 or CPT Codes 28800, 28805);

(xii) Disarticulation of ankle (ICD–9–CM Code 84.13 or V Code V49.74 or CPT 27889);

(xiii) Amputation through malleoli (ICD–9–CM Code 84.14 or V Code V49.75 or CPT Code 27888);

(xiv) Other amputation below knee (ICD–9–CM Code 84.15 or V Code V49.75 or CPT Codes 27880, 27882);

(xv) Disarticulation of knee (ICD–9–CM Code 84.16 or V Code V49.76 or CPT Code 27598);

(xvi) Above knee amputation (ICD–9–CM Code 84.17 or V Code V49.76 or CPT Code 27598);

(xvii) Disarticulation of hip (ICD–9–CM Code 84.18 or V Code V49.77 or CPT Code 27295); and

(xviii) Hindquarter amputation (ICD–9–CM Code 84.19 or CPT Code 27290).

(2)(i) Dependent in 3 or more Activities of Daily Living (eating, dressing, bathing, toileting, transferring, incontinence of bowel and/or bladder), with at least 3 of the dependencies being permanent with a rating of 1, using the Katz scale.

(ii) A score of 10 or lower using the Folstein Mini-Mental State Examination.

(iii) A score of 2 or lower on at least 4 of the 13 motor items using the Functional Independence Measure.

(iv) A score of 30 or lower using the Global Assessment of Functioning.

(f) *VA Form 10–10EZ.* [insert actual photocopy of VA Form 10–10EZ]

OMB Approved No. 2900-0091
Estimated Burden Avg. 20 min.

**Department of Veterans Affairs**

# APPLICATION FOR HEALTH BENEFITS

## SECTION I - GENERAL INFORMATION

1A. TYPE OF BENEFIT(S) APPLIED FOR *(You may check more than one)*

☐ HEALTH SERVICES ☐ NURSING HOME ☐ DOMICILIARY ☐ DENTAL ☐ ENROLLMENT

1B. IF APPLYING FOR HEALTH SERVICES, WHICH VA MEDICAL CENTER OR OUTPATIENT CLINIC DO YOU PREFER

| 2. VETERAN'S NAME *(Last, First, MI)* | 3. OTHER NAMES USED | 4. GENDER *(Check one)* ☐ M ☐ F |
|---|---|---|

| 5. SOCIAL SECURITY NUMBER | 6. CLAIM NUMBER | 7. DATE OF BIRTH *(mm/dd/yyyy)* | 8. RELIGION |
|---|---|---|---|

| 9A. CURRENT MAILING ADDRESS *(Street)* | 9B. CITY | 9C. STATE | 9D. ZIP |
|---|---|---|---|

| 9E. COUNTY | 10. HOME TELEPHONE NUMBER ( ) | 11. WORK TELEPHONE NUMBER ( ) |
|---|---|---|

12. CURRENT MARITAL STATUS *(Check one)* ☐ MARRIED ☐ NEVER MARRIED ☐ SEPARATED ☐ WIDOWED ☐ DIVORCED ☐ UNKNOWN

| 13A. LAST BRANCH OF SERVICE | 13B. LAST ENTRY DATE | 13C. LAST DISCHARGE DATE | 13D. DISCHARGE TYPE | 13E. MILITARY SERVICE NUMBER |
|---|---|---|---|---|

**14. CIRCLE YES OR NO**

| | | | | | |
|---|---|---|---|---|---|
| A. ARE YOU A FORMER PRISONER OF WAR | YES | NO | H. DO YOU HAVE A MILITARY DENTAL INJURY | YES | NO |
| B. DO YOU HAVE A VA SERVICE-CONNECTED RATING | YES | NO | I. DO YOU HAVE A SPINAL CORD INJURY | YES | NO |
| B1. IF YES, WHAT IS YOUR RATED PERCENTAGE | % | | J. ARE YOU ELIGIBLE FOR MEDICAID | YES | NO |
| C. ARE YOU RECEIVING A VA PENSION | YES | NO | K. ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART A | YES | NO |
| D. ARE YOU RETIRED FROM THE MILITARY | YES | NO | K1. EFFECTIVE DATE | | |
| D1. WAS YOUR RETIREMENT THE RESULT OF A DISABILITY | YES | NO | L. ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART B | YES | NO |
| D2. WERE YOU REGULARLY RETIRED - (20+ yrs.) | YES | NO | L1. EFFECTIVE DATE | | |
| E. WERE YOU EXPOSED TO TOXINS IN THE GULF WAR | YES | NO | M. MEDICARE CLAIM NUMBER | | |
| F. WERE YOU EXPOSED TO AGENT ORANGE | YES | NO | N. NAME EXACTLY AS IT APPEARS ON YOUR MEDICARE CARD | | |
| G. WERE YOU EXPOSED TO RADIATION | YES | NO | | | |

| | |
|---|---|
| 15A. VETERAN'S EMPLOYMENT STATUS *(check one)* ☐ NOT EMPLOYED ☐ EMPLOYED ☐ RETIRED *If employed or retired, complete item 15B* / / *Date of retirement* | 15B. COMPANY NAME, ADDRESS AND TELEPHONE NUMBER |
| 16A. SPOUSE'S EMPLOYMENT STATUS *(check one)* ☐ NOT EMPLOYED ☐ EMPLOYED ☐ RETIRED *If employed or retired, complete item 16B* / / *Date of retirement* | 16B. COMPANY NAME, ADDRESS AND TELEPHONE NUMBER |
| 17A. VETERAN'S HEALTH INSURANCE COMPANY | 18A. SPOUSE'S HEALTH INSURANCE COMPANY |
| 17B. NAME OF POLICY HOLDER | 18B. NAME OF POLICY HOLDER |
| 17C. POLICY NUMBER / 17D. GROUP CODE | 18C. POLICY NUMBER / 18D. GROUP CODE |
| 19A. NAME, ADDRESS AND RELATIONSHIP OF NEXT OF KIN | 19B. NEXT OF KIN'S HOME TELEPHONE NUMBER ( ) <br> 19C. NEXT OF KIN'S WORK TELEPHONE NUMBER ( ) |
| 20A. NAME, ADDRESS AND RELATIONSHIP OF EMERGENCY CONTACT | 20B. EMERGENCY CONTACT'S HOME TELEPHONE NUMBER ( ) <br> 20C. EMERGENCY CONTACT'S WORK TELEPHONE NUMBER ( ) |

21. I DESIGNATE THE FOLLOWING INDIVIDUAL TO RECEIVE POSSESSION OF ALL MY PERSONAL PROPERTY LEFT ON PREMISES UNDER VA CONTROL AFTER MY DEPARTURE OR AT THE TIME OF MY DEATH. *(Check one)* ***(This does not constitute a will or transfer of title.)***

☐ EMERGENCY CONTACT ☐ NEXT OF KIN

| 22A. IS NEED FOR CARE DUE TO ON THE JOB INJURY *(Check one)* ☐ YES ☐ NO | 22B. IS NEED FOR CARE DUE TO ACCIDENT *(Check one)* ☐ YES ☐ NO |
|---|---|

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**APPLICATION FOR HEALTH BENEFITS, Continued** | VETERAN'S NAME | SOCIAL SECURITY NUMBER

**SECTION II - FINANCIAL ASSESSMENT**

**IIA - DEPENDENT INFORMATION** ***(Use a separate sheet for additional dependents)***

| | | |
|---|---|---|
| 1. SPOUSE'S NAME *(Last, First, MI)* | 2. CHILD'S NAME *(Last, First, MI)* | |
| 3. SPOUSE'S SOCIAL SECURITY NUMBER | 4. SPOUSE'S DATE OF BIRTH *(mm/dd/yyyy)* | 5. CHILD'S DATE OF BIRTH *(mm/dd/yyyy)* |
| 6. SPOUSE'S ADDRESS *(Street, City, State, ZIP)* | 7. CHILD'S SOCIAL SECURITY NUMBER | |
| 8. SPOUSE'S TELEPHONE NUMBER | 9. CHILD'S RELATIONSHIP TO YOU *(Circle one)* Son Daughter Stepson Stepdaughter | |
| 10. DATE OF MARRIAGE *(mm/dd/yyyy)* | 11. DATE CHILD BECAME YOUR DEPENDENT | |
| 12. IF YOUR SPOUSE OR DEPENDENT CHILD DID NOT LIVE WITH YOU LAST YEAR, ENTER THE AMOUNT YOU CONTRIBUTED TO THEIR SUPPORT SPOUSE $ CHILD $ | 13. EXPENSES PAID BY YOUR DEPENDENT CHILD FOR COLLEGE, VOCATIONAL REHABILITATION OR TRAINING *(tuition, books, materials, etc.)* $ | |
| 14. WAS CHILD PERMANENTLY AND TOTALLY DISABLED BEFORE THE AGE OF 18? ☐ YES ☐ NO | 15. IF CHILD IS BETWEEN 18 AND 23 YEARS OF AGE, DID CHILD ATTEND SCHOOL LAST CALENDAR YEAR? ☐ YES ☐ NO | |

**IIB - FINANCIAL DISCLOSURE**

You are not required to provide the financial information in this Section. However, current law may require VA to consider your household financial situation to determine your eligibility for enrollment and/or cost-free care of your nonservice-connected (NSC) conditions. If you are 0% SC noncompensable or NSC (and are not an Ex-POW, WWI veteran or VA pensioner) and your annual household income (or combined income and net worth) exceeds the established threshold, you must agree to pay VA co-payments for care of your NSC conditions to be eligible for enrollment. See Section III - Consent and Signature.

☐ **YES,** I WILL PROVIDE SPECIFIC INCOME AND/OR ASSET INFORMATION TO HAVE ELIGIBILITY FOR CARE DETERMINED. *Complete all sections below that apply to you with last calendar year's information. Sign and date the application.*

☐ **NO,** I DO NOT WISH TO PROVIDE MY DETAILED FINANCIAL INFORMATION. *I understand I will be assigned the appropriate enrollment priority based on nondisclosure of my financial information. By checking NO and signing below, I am agreeing to pay the applicable VA co-payment. Sign and date the application.*

**IIC - PREVIOUS CALENDAR YEAR GROSS ANNUAL INCOME OF VETERAN, SPOUSE AND DEPENDENT CHILDREN**

| | VETERAN | SPOUSE | CHILDREN |
|---|---|---|---|
| 1. WHAT WAS YOUR GROSS ANNUAL INCOME FROM EMPLOYMENT *(wages, bonuses, tips, etc.)*, AS WELL AS INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS | $ | $ | $ |
| 2. LIST OTHER INCOME AMOUNTS *(Social Security, compensation, pension, interest, dividends) Exclude welfare.* | $ | $ | $ |
| 3. WAS INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS *(If yes, refer to page 2, Section IIC of the instructions.)* ☐ YES ☐ NO | | | |

**IID - DEDUCTIBLE EXPENSES**

| | |
|---|---|
| 1. NON-REIMBURSED MEDICAL EXPENSES PAID BY YOU OR YOUR SPOUSE *(payments for doctors, dentists, drugs, Medicare, health insurance, hospital and nursing home)* | $ |
| 2. AMOUNT YOU PAID LAST CALENDAR YEAR FOR FUNERAL AND BURIAL EXPENSES FOR YOUR DECEASED SPOUSE OR DEPENDENT CHILD *(Also enter spouse or child's information in Section IIA)* | $ |
| 3. AMOUNT YOU PAID LAST CALENDAR YEAR FOR YOUR COLLEGE OR VOCATIONAL EDUCATIONAL EXPENSES *(tuition, books, fees, materials, etc.) DO NOT LIST YOUR DEPENDENTS' EDUCATIONAL EXPENSES.* | $ |

**IIE - NET WORTH**

| | VETERAN | SPOUSE |
|---|---|---|
| 1. CASH, AMOUNT IN BANK ACCOUNTS *(Checking and savings accounts, certificates of deposit, individual retirement accounts, etc.)* | $ | $ |
| 2. MARKET VALUE OF LAND AND BUILDINGS MINUS MORTGAGES AND LIENS. *Do not count your primary home. Include value of farm, ranch, or business assets.* | $ | $ |
| 3. STOCKS AND BONDS AND VALUE OF OTHER PROPERTY OR ASSETS *(art, rare coins, etc.)* MINUS THE AMOUNT YOU OWE ON THESE ITEMS. *Exclude household effects and family vehicles.* | $ | $ |

**SECTION III - CONSENT AND SIGNATURE**

**CO-PAYMENT NOTICE:** If you are a 0% service-connected noncompensable or a nonservice-connected veteran (and are not an Ex-POW, WWI veteran or VA pensioner) **and** your household income (or combined income and net worth) exceeds the established threshold, you may be eligible for enrollment only if you agree to pay VA co-payments for treatment of your NSC conditions. By signing this application you are agreeing to pay the applicable VA co-payment if required by law.

**I CERTIFY THE FOREGOING STATEMENT(S) ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND ABILITY.** | DATE *(mm/dd/yyyy)*

**SIGN HERE**

*(Signature of applicant or applicant's representative)*

**THE LAW PROVIDES SEVERE PENALTIES FOR WILLFUL SUBMISSION OF FALSE INFORMATION.**

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(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900–0091.)

AUTHORITY: 38 U.S.C. 101, 501, 1701, 1705, 1710, 1721, 1722

[64 FR 54212, Oct. 6, 1999]

### § 17.37 Enrollment not required—provision of hospital and outpatient care to veterans.

Even if not enrolled in the VA healthcare system:

(a) A veteran rated for service-connected disabilities at 50 percent or greater will receive VA hospital and outpatient care provided for in the ''medical benefits package'' set forth in § 17.38.

(b) A veteran who has a service-connected disability will receive VA hospital and outpatient care provided for in the ''medical benefits package'' set forth in § 17.38 for that service-connected disability.

(c) A veteran who was discharged or released from active military service for a disability incurred or aggravated in the line of duty will receive VA hospital and outpatient care provided for in the ''medical benefits package'' set forth in § 17.38 for that disability for the 12-month period following discharge or release.

(d) When there is a compelling medical need to complete a course of VA treatment started when the veteran was enrolled in the VA healthcare system, a veteran will receive that treatment.

(e) Subject to the provisions of § 21.240, a veteran participating in VA's vocational rehabilitation program described in §§ 21.1 through 21.430 will receive VA hospital and outpatient care provided for in the ''medical benefits package'' set forth in § 17.38.

(f) A veteran may receive VA hospital and outpatient care based on factors other than veteran status (*e.g.,* a veteran who is a private-hospital patient and is referred to VA for a diagnostic test by that hospital under a sharing contract; a veteran who is a VA employee and is examined to determine physical or mental fitness to perform official duties; a Department of Defense retiree under a sharing agreement).

(g) For care not provided within a State, a veteran may receive VA hospital and outpatient care provided for in the ''medical benefits package'' set forth in § 17.38 if authorized under the provisions of 38 U.S.C. 1724 and 38 CFR 17.35.

(h) Commonwealth Army veterans and new Philippine Scouts may receive hospital and outpatient care provided for in the ''medical benefits package'' set forth in § 17.38 if authorized under the provisions of 38 U.S.C. 1724 and 38 CFR 17.35.

(i) A veteran may receive certain types of VA hospital and outpatient care not included in the ''medical benefits package'' set forth in § 17.38 if authorized by statute or other sections of 38 CFR (*e.g.*, humanitarian emergency care for which the individual will be billed, compensation and pension examinations, dental care, domiciliary care, nursing home care, readjustment counseling, care as part of a VA-approved research project, seeing-eye or guide dogs, sexual trauma counseling and treatment, special registry examinations).

(j) A veteran may receive an examination to determine whether the veteran is catastrophically disabled and therefore eligible for inclusion in priority category 4.

(Authority: 38 U.S.C. 101, 501, 1701, 1705, 1710, 1721, 1722)

[64 FR 54217, Oct. 6, 1999]

### § 17.38 Medical benefits package.

(a) Subject to paragraphs (b) and (c) of this section, the following hospital and outpatient care constitutes the ''medical benefits package'' (basic care and preventive care):

(1) Basic care.

(i) Outpatient medical, surgical, and mental healthcare, including care for substance abuse.

(ii) Inpatient hospital, medical, surgical, and mental healthcare, including care for substance abuse.

(iii) Prescription drugs, including over-the-counter drugs and medical and surgical supplies available under the VA national formulary system.

(iv) Emergency care in VA facilities; and emergency care in non-VA facilities in accordance with sharing contracts or if authorized by §§ 17.52(a)(3), 17.53, 17.54, 17.120–132.

(v) Bereavement counseling as authorized in § 17.98.

(vi) Comprehensive rehabilitative services other than vocational services provided under 38 U.S.C. chapter 31.

(vii) Consultation, professional counseling, training, and mental health services for the members of the immediate family or legal guardian of the veteran or the individual in whose household the veteran certifies an intention to live, if needed to treat:

(A) The service-connected disability of a veteran; or

(B) The nonservice-connected disability of a veteran where these services were first given during the veteran's hospitalization and continuing them is essential to permit the veteran's release from inpatient care.

(viii) Durable medical equipment and prosthetic and orthotic devices, including eyeglasses and hearing aids as authorized under § 17.149.

(ix) Home health services authorized under 38 U.S.C. 1717 and 1720C.

(x) Reconstructive (plastic) surgery required as a result of disease or trauma, but not including cosmetic surgery that is not medically necessary.

(xi) Respite, hospice, and palliative care.

(xii) Payment of travel and travel expenses for veterans eligible under § 17.143 if authorized by that section.

(xiii) Pregnancy and delivery services, to the extent authorized by law.

(xiv) Completion of forms (*e.g.*, Family Medical Leave forms, life insurance applications, Department of Education forms for loan repayment exemptions based on disability, non-VA disability program forms) by healthcare professionals based on an examination or knowledge of the veteran's condition, but not including the completion of forms for examinations if a third party customarily will pay health care practitioners for the examination but will not pay VA.

(2) Preventive care, as defined in 38 U.S.C. 1701(9), which includes:

(i) Periodic medical exams.

(ii) Health education, including nutrition education.

(iii) Maintenance of drug-use profiles, drug monitoring, and drug use education.

(iv) Mental health and substance abuse preventive services.

(v) Immunizations against infectious disease.

(vi) Prevention of musculoskeletal deformity or other gradually developing disabilities of a metabolic or degenerative nature.

(vii) Genetic counseling concerning inheritance of genetically determined diseases.

(viii) Routine vision testing and eyecare services.

(ix) Periodic reexamination of members of high-risk groups for selected diseases and for functional decline of sensory organs, and the services to treat these diseases and functional declines.

(b) *Provision of the ''medical benefits package''.* Care referred to in the ''medical benefits package'' will be provided to individuals only if it is determined by appropriate healthcare professionals that the care is needed to promote, preserve, or restore the health of the individual and is in accord with generally accepted standards of medical practice.

(1) *Promote health.* Care is deemed to promote health if the care will enhance the quality of life or daily functional level of the veteran, identify a predisposition for development of a condition or early onset of disease which can be partly or totally ameliorated by monitoring or early diagnosis and treatment, and prevent future disease.

(2) *Preserve health.* Care is deemed to preserve health if the care will maintain the current quality of life or daily functional level of the veteran, prevent the progression of disease, cure disease, or extend life span.

(3) *Restoring health.* Care is deemed to restore health if the care will restore the quality of life or daily functional level that has been lost due to illness or injury.

(c) In addition to the care specifically excluded from the ''medical benefits package'' under paragraphs (a) and (b) of this section, the ''medical benefits package'' does not include the following:

(1) Abortions and abortion counseling.

(2) In vitro fertilization.

(3) Drugs, biologicals, and medical devices not approved by the Food and Drug Administration unless the treating medical facility is conducting formal clinical trials under an Investigational Device Exemption (IDE) or an Investigational New Drug (IND) application, or the drugs, biologicals, or

medical devices are prescribed under a compassionate use exemption.

(4) Gender alterations.

(5) Hospital and outpatient care for a veteran who is either a patient or inmate in an institution of another government agency if that agency has a duty to give the care or services.

(6) Membership in spas and health clubs.

(Authority: 38 U.S.C. 101, 501, 1701, 1705, 1710, 1721, 1722)

[64 FR 54217, Oct. 6, 1999]

### § 17.40 Additional services for indigents.

In addition to the usual medical services agreed upon between the governments of the United States and the Republic of the Philippines to be made available to patients for whom the Department of Veterans Affairs has authorized care at the Veterans Memorial Medical Center, any such patient determined by the U.S. Department of Veterans Affairs to be indigent or without funds may be furnished toilet articles and barber services, including haircutting and shaving necessary for hygienic reasons.

[33 FR 5299, Apr. 3, 1968, as amended at 47 FR 58247, Dec. 30, 1982. Redesignated at 61 FR 21965, May 13, 1996]

## EXAMINATIONS AND OBSERVATION AND EXAMINATION

### § 17.41 Persons eligible for hospital observation and physical examination.

Hospitalization for observation and physical (including mental) examination may be effected when requested by an authorized official, or when found necessary in examination of the following persons:

(a) Claimants or beneficiaries of VA for purposes of disability compensation, pension, participation in a rehabilitation program under 38 U.S.C. chapter 31, and Government insurance. (38 U.S.C. 1711(a))

(b) Claimants or beneficiaries referred to a diagnostic center for study to determine the clinical identity of an obscure disorder.

(c) Employees of the Department of Veterans Affairs when necessary to determine their mental or physical fitness to perform official duties.

(d) Claimants or beneficiaries of other Federal agencies:

(1) Department of Justice—plaintiffs in Government insurance suits.

(2) United States Civil Service Commission—annuitants or applicants for retirement annuity, and such examinations of prospective appointees as may be requested.

(3) Office of Workers' Compensation Programs—to determine identity, severity, or persistence of disability.

(4) Railroad Retirement Board—applicants for annuity under Public No. 162, 75th Congress.

(5) Other Federal agencies.

(e) Pensioners of nations allied with the United States in World War I and World War II, upon authorization from accredited officials of the respective governments.

[13 FR 7156, Nov. 27, 1948, as amended at 16 FR 12091, Nov. 30, 1951; 19 FR 6716, Oct. 19, 1954; 32 FR 13813, Oct. 4, 1967; 39 FR 32606, Sept. 10, 1974; 49 FR 5616, Feb. 14, 1984. Redesignated and amended at 61 FR 21965, 21966, May 13, 1996]

### § 17.42 Examinations on an outpatient basis.

Physical examinations on an outpatient basis may be furnished to applicants who have been tentatively determined to be eligible for Department of Veterans Affairs hospital or domiciliary care to determine their need for such care and to the same categories of persons for whom hospitalization for observation and examination may be authorized under § 17.41.

[35 FR 6586, Apr. 24, 1970. Redesignated and amended at 61 FR 21965, 21966, May 13, 1996]

## HOSPITAL, DOMICILIARY AND NURSING HOME CARE

### § 17.43 Persons entitled to hospital or domiciliary care.

Hospital or domiciliary care may be provided:

(a) Not subject to the eligibility provisions of 38 U.S.C. 1710, 1722, and 1729, and 38 CFR 17.44 and 17.45, for:

(1) Persons in the Armed Forces when duly referred with authorization therefor, may be furnished hospital care.

Emergency treatment may be rendered, without obtaining formal authorization, to such persons upon their own application, when absent from their commands. Identification of active duty members of the uniformed services will be made by military identification card.

(2) Hospital care may be provided, upon authorization, for beneficiaries of the Public Health Service, Office of Workers' Compensation Programs, and other Federal agencies.

(3) Pensioners of nations allied with the United States in World War I and World War II may be supplied hospital care when duly authorized.

(b) Emergency hospital care may be provided for:

(1) Persons having no eligibility, as a humanitarian service.

(2) Persons admitted because of presumed discharge or retirement from the Armed Forces, but subsequently found to be ineligible as such.

(3) Employees (not potentially eligible as ex-members of the Armed Forces) and members of their families, when residing on reservations of field facilities of the Department of Veterans Affairs, and when they cannot feasibly obtain emergency treatment from private facilities.

(c) Hospital care when incidental to, and to the extent necessary for, the use of a specialized Department of Veterans Affairs medical resource pursuant to a sharing agreement entered into under §17.210, may be authorized for any person designated by the other party to the agreement as a patient to be benefited under the agreement.

(d) The authorization of services under any provision of this section, except services for eligible veterans, is subject to charges as required by §17.101.

[23 FR 6498, Aug. 22, 1958, as amended at 24 FR 8327, Oct. 14, 1959; 32 FR 6841, May 4, 1967; 34 FR 9340, June 13, 1969; 35 FR 6586, Apr. 24, 1970; 39 FR 32606, Sept. 10, 1974. Redesignated and amended at 61 FR 21965, 21966, May 13, 1996; 64 FR 54218, Oct. 6, 1999]

### §17.44 Hospital care for certain retirees with chronic disability (Executive Orders 10122, 10400 and 11733).

Hospital care may be furnished when beds are available to members or former members of the uniformed services (Army, Navy, Air Force, Marine Corps, Coast Guard, Coast and Geodetic Survey, now National Oceanic and Atmospheric Administration hereinafter referred to as *NOAA*, and Public Health Service) temporarily or permanently retired for physical disability or receiving disability retirement pay who require hospital care for chronic diseases and who have no eligibility for hospital care under laws governing the Department of Veterans Affairs, or who having eligibility do not elect hospitalization as Department of Veterans Affairs beneficiaries. Care under this section is subject to the following conditions:

(a) Persons defined in this section who are members or former members of the active military, naval, or air service must agree to pay the subsistence rate set by the Secretary of Veterans Affairs, except that no subsistence charge will be made for those persons who are members or former members of the Public Health Service, Coast Guard, Coast and Geodetic Survey now *NOAA*, and enlisted personnel of the Army, Navy, Marine Corps, and Air Force.

(b) Under this section, the term *chronic diseases* shall include chronic arthritis, malignancy, psychiatric disorders, poliomyelitis with residuals, neurological disabilities, diseases of the nervous system, severe injuries to the nervous system, including quadriplegia, hemiplegia and paraplegia, tuberculosis, blindness and deafness requiring definitive rehabilitation, disability from major amputation, and other diseases as may be agreed upon from time to time by the Under Secretary for Health and designated officials of the Department of Defense and Department of Health and Human Services. For the purpose of this section, blindness is defined as corrected visual acuity of 20/200 or less in the better eye, or corrected central visual acuity of more than 20/200 if there is a field defect in which the peripheral field has contracted to such an extent that its widest diameter subtends the widest diameter of the field of the better eye at an angle no greater than 20°.

(c) In the case of persons who are former members of the Coast and Geodetic Survey, care may be furnished under this section even though their retirement for disability was from the Environmental Science Services Administration or NOAA.

[34 FR 9340, June 13, 1969, as amended at 39 FR 1841, Jan. 15, 1974; 47 FR 58247, Dec. 30, 1982. Redesignated at 61 FR 21965, May 13, 1996, as amended at 62 FR 17072, Apr. 9, 1997]

### § 17.45 Hospital care for research purposes.

Subject to the provisions of § 17.62(g), any person who is a bona fide volunteer may be admitted to a Department of Veterans Affairs hospital when the treatment to be rendered is part of an approved Department of Veterans Affairs research project and there are insufficient veteran-patients suitable for the project.

[35 FR 11470, July 17, 1970. Redesignated at 61 FR 21965, May 13, 1996]

### § 17.46 Eligibility for hospital, domiciliary or nursing home care of persons discharged or released from active military, naval, or air service.

(a) In furnishing hospital care under 38 U.S.C. 1710(a)(1), VA officials shall:

(1) If the veteran is in immediate need of hospitalization, furnish care at VA facility where the veteran applies or, if that facility is incapable of furnishing care, arrange to admit the veteran to the nearest VA medical center, or Department of Defense hospital with which VA has a sharing agreement under 38 U.S.C. 8111, which is capable of providing the needed care, or if VA or DOD facilities are not available, arrange for care on a contract basis if authorized by 38 U.S.C. 1703 and 38 CFR 17.52; or

(2) If the veteran needs non-immediate hospitalization, schedule the veteran for admission at VA facility where the veteran applies, if the schedule permits, or refer the veteran for admission or scheduling for admission at the nearest VA medical center, or Department of Defense facility with which VA has a sharing agreement under 38 U.S.C. 8111.

(Authority: 38 U.S.C. 1703, 1710; secs. 19011–19012, Pub. L. 99–272)

(b) Domiciliary care may be furnished when needed to:

(1) Any veteran whose annual income does not exceed the maximum annual rate of pension payable to a veteran in need of regular aid and attendance, or

(2) Any veteran who the Secretary determines had no adequate means of support. An additional requirement for eligibility for domiciliary care is the ability of the veteran to perform the following:

(i) Perform without assistance daily ablutions, such as brushing teeth; bathing; combing hair; body eliminations.

(ii) Dress self, with a minimum of assistance.

(iii) Proceed to and return from the dining hall without aid.

(iv) Feed Self.

(v) Secure medical attention on an ambulatory basis or by use of personally propelled wheelchair.

(vi) Have voluntary control over body eliminations or control by use of an appropriate prosthesis.

(vii) Share in some measure, however slight, in the maintenance and operation of the facility.

(viii) Make rational and competent decisions as to his or her desire to remain or leave the facility.

(Authority: 38 U.S.C. 1710(b), sec. 102, Pub. L. 100–322)

[24 FR 8328, Oct. 4, 1959, as amended at 30 FR 1787, Feb. 9, 1965; 32 FR 13813, Oct. 4, 1967; 34 FR 9340, June 13, 1969; 39 FR 1841, Jan. 15, 1974; 45 FR 6935, Jan. 31, 1980; 51 FR 25064, July 10, 1986; 52 FR 11259, Apr. 8, 1987; 53 FR 9627, Mar. 24, 1988; 53 FR 32391, Aug. 25, 1988; 56 FR 5757, Feb. 13, 1991. Redesignated and amended at 61 FR 21965, 21966, May 13, 1996]

### § 17.47 Considerations applicable in determining eligibility for hospital, nursing home or domiciliary care.

(a)(1) For applicants discharged or released for disability incurred or aggravated in line of duty and who are not in receipt of compensation for service-connected or service-aggravated disability, the official records of the Armed Forces relative to findings of line of duty for its purposes will be accepted in determining eligibility for hospital care. Where the official records of the Armed Forces show a finding of disability not incurred or aggravated in line of duty and evidence is

submitted to the Department of Veterans Affairs which permits of a different finding, the decision of the Armed Forces will not be binding upon the Department of Veterans Affairs, which will be free to make its own determination of line of duty incurrence or aggravation upon evidence so submitted. It will be incumbent upon the applicant to present controverting evidence and, until such evidence is presented and a determination favorable to the applicant is made by the Department of Veterans Affairs, the finding of the Armed Forces will control and hospital care will not be authorized. Such controverting evidence, when received from an applicant, will be referred to the adjudicating agency which would have jurisdiction if the applicant was filing claim for pension or disability compensation, and the determination of such agency as to line of duty, which is promptly to be communicated to the head of the field facility receiving the application for hospital care, will govern the facility Director's disapproval or approval of admission, other eligibility requirements having been met. Where the official records of the Armed Forces show that the disability for which a veteran was discharged or released from the Armed Forces under other than dishonorable conditions was incurred or aggravated in the line of duty, such showing will be accepted for the purpose of determining his or her eligibility for hospitalization, notwithstanding the fact that the Department of Veterans Affairs has made a determination in connection with a claim for monetary benefits that the disability was incurred or aggravated not in line of duty.

(2) In those exceptional cases where the official records of the Armed Forces show discharge or release under other than dishonorable conditions because of expiration of period of enlistment or any other reason except disability, but also show a disability incurred or aggravated in line of duty during the said enlistment; and the disability so recorded is considered in medical judgment to be or to have been of such character, duration, and degree as to have justified a discharge or release for disability had the period of enlistment not expired or other reason for discharge or release been given, the Under Secretary for Health, upon consideration of a clear, full statement of circumstances, is authorized to approve admission of the applicant for hospital care, provided other eligibility requirements are met. A typical case of this kind will be one where the applicant was under treatment for the said disability recorded during his or her service at the time discharge or release was given for the reason other than disability.

(b)(1) Under 38 U.S.C. 1710(a)(1), veterans who are receiving disability compensation awarded under §3.800 of this chapter, where a disease, injury or the aggravation of an existing disease or injury occurs as a result of VA examination, medical or surgical treatment, or of hospitalization in a VA health care facility or of participation in a rehabilitation program under 38 U.S.C. ch. 31, under any law administered by VA and not the result of his/her own willful misconduct. Treatment may be provided for the disability for which the compensation is being paid or for any other disability. Treatment under the authority of 38 U.S.C. 1710(a)(1) may not be authorized during any period when disability compensation under §3.800 of this title is not being paid because of the provision of §3.800(a)(2), except to the extent continuing eligibility for such treatment is provided for in the judgment for settlement described in §3.800(a)(2) of this title.

(Authority: 38 U.S.C. 1710(a); sec. 701, Pub. L. 98–160, Pub. L. 99–272)

(2) For purposes of eligibility for domiciliary care, the phrase *no adequate means of support* refers to an applicant for domiciliary care whose annual income exceeds the annual rate of pension for a veteran in receipt of regular aid and attendance, as defined in 38 U.S.C. 1503, but who is able to demonstrate to competent VA medical authority, on the basis of objective evidence, that deficits in health and/or functional status render the applicant incapable of pursuing substantially gainful employment, as determined by the Chief of Staff, and who is otherwise

without the means to provide adequately for self, or be provided for in the community.

(Authority: 38 U.S.C. 1710(a); sec. 701, Pub. L. 98–160, Pub. L. 99–272)

(c) A *disability, disease, or defect* will comprehend any acute, subacute, or chronic disease (or a general medical, tuberculous, or neuropsychiatric type) of any acute, subacute, or chronic surgical condition susceptible of cure or decided improvement by hospital care; or any condition which does not require hospital care for an acute or chronic condition but requires domiciliary care. Domiciliary care, as the term implies, is the provision of a home, with such ambulant medical care as is needed. To be provided with domiciliary care, the applicant must consistently have a disability, disease, or defect which is essentially chronic in type and is producing disablement of such degree and probable persistency as will incapacitate from earning a living for a prospective period.

(Authority: 38 U.S.C. 1701, 1710)

(d)(1) For purposes of determining eligibility for hospital or nursing home care under §17.47(a), a veteran will be determined unable to defray the expenses of necessary care if the veteran agrees to provide verifiable evidence, as determined by the Secretary, that:

(i) The veteran is eligible to receive medical assistance under a State plan approved under title XIX of the Social Security Act;

(Authority: 42 U.S.C. 1396 *et seq.*)

(ii) The veteran is in receipt of pension under 38 U.S.C. 1521; or

(iii) The veteran's attributable income does not exceed $15,000 if the veteran has no dependents, $18,000 if the veteran has one dependent, plus $1,000 for each additional dependent.

(Authority: 38 U.S.C. 1722; sec. 19011, Pub. L. 99–272)

(2) For purposes of determining eligibility for hospital or nursing home care under §17.47(c), a veteran will be determined eligible for necessary care if the veteran agrees to provide verifiable evidence, as determined by the Secretary, that: The veteran's attributable income does not exceed $20,000 if the veteran has no dependents, $25,000 if the veteran has one dependent, plus $1,000 for each additional dependent.

(Authority: 38 U.S.C. 1722; sec. 19011, Pub. L. 99–272)

(3) Effective on January 1 of each year after calendar year 1986, the amounts set forth in paragraph (d)(1) and (2) of this section shall be increased by the percentage by which the maximum rates of pension were increased under 38 U.S.C. 1111(a), during the preceding year.

(Authority: 38 U.S.C. 1722; sec. 19011, Pub. L. 99–272)

(4) Determinations with respect to attributable income made under paragraph (d)(1) and (2) of this section, shall be made in the same manner, including the same sources of income and exclusions from income, as determinations with respect to income are made for determining eligibility for pension under §§3.271 and 3.272 of this title. The term *attributable income* means income of a veteran for the calendar year preceding application for care, determined in the same manner as the manner in which a determination is made of the total amount of income by which the rate of pension for such veteran under 38 U.S.C. 1521 would be reduced if such veteran were eligible for pension under that section.

(Authority: 38 U.S.C. 1722; sec. 19011, Pub. L. 99–272)

(5) Notwithstanding the attributable income of a veteran, VA may determine that such veteran is not eligible under paragraph (d)(1) and (2) of this section if the corpus of the estate of the veteran is such that under all the circumstances it is reasonable that some part of the corpus of the estate of the veteran be consumed for the veteran's maintenance. The corpus of the estate of a veteran shall be determined in the same manner as determinations are made with respect to the determinations of eligibility for pension under §3.275 of this chapter. The term *corpus of the estate of the veteran* includes the corpus of the estates of the veteran's spouse and dependent children, if any.

(Authority: 38 U.S.C. 1722; sec. 19011, Pub. L. 99–272)

(6) In order to avoid hardship VA may determine that a veteran is eligible for care notwithstanding that the veteran does not meet the income requirements established in paragraph (d)(1)(iii) or (d)(2) of this section, if projections of the veteran's income for the year following application for care are substantially below the income requirements established in paragraph (d)(1)(iii) or (d)(2) of this section.

(Authority: 38 U.S.C. 1722; sec. 19011, Pub. L. 99–272)

(e)(1) If VA determines that an individual was incorrectly charged a copayment, VA will refund the amount of any copayment actually paid by that individual.

(Authority: 38 U.S.C. 501; sec. 19011, Pub. L. 99–272)

(2) In the event a veteran provided inaccurate information on an application and is incorrectly deemed eligible for care under 38 U.S.C. 1710(a)(1) rather than §1710(a)(2), VA shall retroactively bill the veteran for the applicable copayment.

(Authority: 38 U.S.C. 501 and 1710; sec. 19011, Pub. L. 99–272)

(f) If a veteran who receives hospital or nursing home care under 38 U.S.C. 1710(a)(2) or outpatient care under 38 U.S.C. 1712(a)(4) by virtue of the veteran's eligibility for hospital care under 38 U.S.C. 1710(a), fails to pay to the United States the amounts agreed to under those sections shall be grounds for determining, in accordance with guidelines promulgated by the Under Secretary for Health, that the veteran is not eligible to receive further care under those sections until such amounts have been paid in full.

(Authority: 38 U.S.C. 1710, 1721; sec. 19011, Pub. L. 99–272)

(g)(1) Persons hospitalized who have no service-connected disabilities pursuant to §17.47, and/or persons receiving outpatient medical services pursuant to paragraphs (e), (f), (i), (j), and/or (k) of §17.60 who have no service-connected disabilities who it is believed may be eligible for hospital care and/or medical services, or reimbursement for the expenses of care or services for all or part of the cost thereof by reason of the following:

(i) Membership in a union, fraternal or other organization, or

(ii) Coverage under an insurance policy, or contract, medical, or hospital service agreement, membership, or subscription contract or similar arrangement under which health services for individuals are provided or the expenses of such services are paid, will not be furnished hospital care or medical services without charge therefore to the extent of the amount for which such parties referred to in paragraphs (g)(1)(i) or (g)(1)(ii) of this section, are, will become, or may be liable. Persons believed entitled to care under any of the plans discussed above will be required to provide such information as the Secretary may require. Provisions of this paragraph are effective April 7, 1986, except in the case of a health care policy or contract that was entered into before that date, the effective date shall be the day after the plan was modified or renewed or on which there was any change in premium or coverage and will apply only to care and services provided by VA after the date the plan was modified, renewed, or on which there was any change in premium or coverage.

(Authority: 38 U.S.C. 1729; sec. 19013, Pub. L. 99–272)

(2) Persons hospitalized for the treatment of nonservice-connected disabilities pursuant to §17.47, or persons receiving outpatient medical services pursuant to paragraph (e), (f), (h), (i), (j), or (k) of §17.60, and who it is believed may be entitled to hospital care and/or medical services or to reimbursement for all or part of the cost thereof from any one or more of the following parties:

(i) *Workers' Compensation* or employer's liability statutes, State or Federal;

(ii) By reason of statutory or other relationships with third parties, including those liable for damages because of negligence or other legal wrong;

(iii) By reason of a statute in a State, or political subdivision of a State;

(A) Which requires automobile accident reparations or;

(B) Which provides compensation or payment for medical care to victims suffering personal injuries as the result of a crime of personal violence;

(iv) Right to maintenance and cure in admiralty;

will not be furnished hospital care or medical services without charge therefore to the extent of the amount for which such parties are, will become, or may be liable. Persons believed entitled to care under circumstances described in paragraph (g)(2)(ii) of this section will be required to complete such forms as the Secretary may require, such as a power of attorney and assignment. Notice of this assignment will be mailed promptly to the party or parties believed to be liable. When the amount of charges is ascertained, a bill therefore will be mailed to such party or parties. Persons believed entitled to care under circumstances described in paragraph (g)(2)(i) or (g)(2)(iii) of this section will be required to complete such forms as the Secretary may require.

(Authority: 38 U.S.C. 1729, sec. 19013, Pub. L. 99–272)

(h) Within the limits of Department of Veterans Affairs facilities, any veteran who is receiving nursing home care in a hospital under the direct jurisdiction of the Department of Veterans Affairs, may be furnished medical services to correct or treat any nonservice-connected disability of such veteran, in addition to treatment incident to the disability for which the veteran is hospitalized, if the veteran is willing, and such services are reasonably necessary to protect the health of such veteran.

(i) *Participating in a rehabilitation program under 38 U.S.C. chapter 31* refers to any veteran

(1) Who is eligible for and entitled to participate in a rehabilitation program under chapter 31.

(i) Who is in an extended evaluation period for the purpose of determining feasibility, or

(ii) For whom a rehabilitation objective has been selected, or

(iii) Who is pursuing a rehabilitation program, or

(iv) Who is pursuing a program of independent living, or

(v) Who is being provided employment assistance under 38 U.S.C. chapter 31, and

(2) Who is medically determined to be in need of hospital care or medical services (including dental) for any of the following reasons:

(i) Make possible his or her entrance into a rehabilitation program; or

(ii) Achieve the goals of the veteran's vocational rehabilitation program; or

(iii) Prevent interruption of a rehabilitation program; or

(iv) Hasten the return to a rehabilitation program of a veteran in interrupted or leave status; or

(v) Hasten the return to a rehabilitation program of a veteran placed in discontinued status because of illness, injury or a dental condition; or

(vi) Secure and adjust to employment during the period of employment assistance; or

(vii) To enable the veteran to achieve maximum independence in daily living.

(Authority: 38 U.S.C. 3104(a)(9); Pub. L. 96–466, sec. 101(a))

(j) Veterans eligible for treatment under chapter 17 of 38 U.S.C. who are alcohol or drug abusers or who are infected with the human immunodeficiency virus (HIV) shall not be discriminated against in admission or treatment by any Department of Veterans Affairs health care facility solely because of their alcohol or drug abuse or dependency or because of their viral infection. This does not preclude the rule of clinical judgment in determining appropriate treatment which takes into account the patient's immune status and/or the infectivity of the HIV or other pathogens (such as tuberculosis, cytemegalovirus, cryptosporidiosis, etc.). Hospital Directors are responsible for assuring that admission criteria of all programs in the medical center do not discriminate solely on the basis of alcohol, drug abuse or infection with human immunodeficiency virus. Quality Assurance Programs should include indicators and monitors for nondiscrimination.

(Authority: 38 U.S.C. 7333)

(k) In seeking medical care from VA under 38 U.S.C. 1710 or 1712, a veteran

shall furnish such information and evidence as the Secretary may require to establish eligibility.

(Authority: 38 U.S.C. 1722; sec. 19011, Pub. L. 99–272)

[32 FR 13813, Oct. 4, 1967]

EDITORIAL NOTE: For FEDERAL REGISTER citations affecting §17.47, see the List of CFR Sections Affected in the Finding Aids section of this volume.

### §17.49 Priorities for inpatient care.

The Under Secretary for Health may establish priorities for admission to hospital, nursing home, and domiciliary care consistent with §17.46 to facilitate management of VA health care facilities and to help assure prompt delivery of care.

(Authority: 38 U.S.C. 501 and 1721)

[51 FR 25066, July 10, 1986, as amended at 61 FR 21966, May 13, 1996; 62 FR 17072, Apr. 9, 1997]

USE OF DEPARTMENT OF DEFENSE, PUBLIC HEALTH SERVICE OR OTHER FEDERAL HOSPITALS

### §17.50 Use of Department of Defense, Public Health Service or other Federal hospitals with beds allocated to the Department of Veterans Affairs.

Hospital facilities operated by the Department of Defense or the Public Health Service (or any other agency of the United States Government) may be used for the care of Department of Veterans Affairs patients pursuant to agreements between the Department of Veterans Affairs and the department or agency operating the facility. When such an agreement has been entered into and a bed allocation for Department of Veterans Affairs patients has been provided for in a specific hospital covered by the agreement, care may be authorized within the bed allocation for any veteran eligible under 38 U.S.C. 1710 or 38 CFR 17.44. Care in a Federal facility not operated by the Department of Veterans Affairs, however, shall not be authorized for any military retiree whose sole basis for eligibility is under §17.46b, or, except in Alaska and Hawaii, for any retiree of the uniformed services suffering from a chronic disability whose entitlement is under §17.46b, §17.47(b)(2) or §17.47(c)(2) regardless of whether he or she may have dual eligibility under other provisions of §17.47.

[39 FR 1842, Jan. 15, 1974, as amended at 45 FR 6936, Jan. 31, 1980, as amended at 61 FR 21966, May 13, 1996]

### §17.51 Emergency use of Department of Defense, Public Health Service or other Federal hospitals.

Hospital care in facilities operated by the Department of Defense or the Public Health Service (or any other agency of the U.S. Government) which do not have beds allocated for the care of Department of Veterans Affairs patients may be authorized subject to the limitations enumerated in §17.50 only in emergency circumstances for any veteran otherwise eligible for hospital care under 38 U.S.C. 1710 or 38 CFR 17.46.

[33 FR 19010, Dec. 20, 1968. Redesignated and amended at 61 FR 21965, 21966, May 13, 1996]

USE OF PUBLIC OR PRIVATE HOSPITALS

### §17.52 Hospital care and medical services in non-VA facilities.

(a) When VA facilities or other government facilities are not capable of furnishing economical hospital care or medical services because of geographic inaccessibility or are not capable of furnishing care or services required, VA may contract with non-VA facilities for care in accordance with the provisions of this section. When demand is only for infrequent use, individual authorizations may be used. Care in public or private facilities, however, subject to the provisions of §17.53 through f, will only be authorized, whether under a contract or an individual authorization, for

(1) Hospital care or medical services to a veteran for the treatment of—

(i) A service-connected disability; or

(ii) A disability for which a veteran was discharged or released from the active military, naval, or air service or

(iii) A disability of a veteran who has a total disability permanent in nature from a service-connected disability, or

(iv) For a disability associated with and held to be aggravating a service-connected disability, or

(v) For any disability of a veteran participating in a rehabilitation program under 38 U.S.C. ch. 31 and when there is a need for hospital care or medical services for any of the reasons enumerated in § 17.48(j).

(Authority: 38 U.S.C. 1703, 3104; sec. 101, Pub. L. 96–466; sec. 19012, Pub. L. 99–272)

(2) Medical services for the treatment of any disability of—

(i) A veteran who has a service-connected disability rated at 50 percent or more,

(ii) A veteran who has received VA inpatient care for treatment of non-service-connected conditions for which treatment was begun during the period of inpatient care. The treatment period (to include care furnished in both facilities of VA and non-VA facilities or any combination of such modes of care) may not continue for a period exceeding 12 months following discharge from the hospital except when it is determined that a longer period is required by virtue of the disabilities being treated, and

(iii) A veteran of the Mexican border period or World War I or who is in receipt of increased pension or additional compensation based on the need for aid and attendance or housebound benefits when it has been determined based on an examination by a physician employed by VA (or, in areas where no such physician is available, by a physician carrying out such function under a contract or fee arrangement), that the medical condition of such veteran precludes appropriate treatment in VA facilities;

(Authority: 38 U.S.C. 1703; sec. 19012, Pub. L. 99–272)

(3) Hospital care or medical services for the treatment of medical emergencies which pose a serious threat to the life or health of a veteran receiving hospital care or medical services in a facility over which the Secretary has direct jurisdiction or government facility with which the Secretary contracts, and for which the facility is not staffed or equipped to perform, and transfer to a public or private hospital which has the necessary staff or equipment is the only feasible means of providing the necessary treatment, until such time following the furnishing of care in the non-VA facility as the veteran can be safely transferred to a VA facility;

(Authority: 38 U.S.C. 1703; sec. 19012, Pub. L. 99–272)

(4) Hospital care for women veterans;

(Authority: 38 U.S.C. 1703; sec. 19012, Pub. L. 99–272)

(5) Through September 30, 1988, hospital care or medical services that will obviate the need for hospital admission for veterans in the Commonwealth of Puerto Rico, except that the dollar expenditure in Fiscal year 1986 cannot exceed 85% of the Fiscal year 1985 obligations, in Fiscal year 1987 the dollar expenditure cannot exceed 50% of the Fiscal year 1985 obligations and in Fiscal year 1988 the dollar expenditure cannot exceed 25% of the Fiscal year 1985 obligations.

(Authority: 38 U.S.C. 1703; sec. 102, Pub. L. 99–166; sec. 19012, Pub. L. 99–272)

(6) Hospital care or medical services that will obviate the need for hospital admission for veterans in Alaska, Hawaii, Virgin Islands and other territories of the United States except that the annually determined hospital patient load and incidence of the furnishing of medical services to veterans hospitalized or treated at the expense of VA in government and non-VA facilities in each such State or territory shall be consistent with the patient load or incidence of the provision of medical services for veterans hospitalized or treated by VA within the 48 contiguous States.

(Authority: 38 U.S.C. 1703; sec. 19012, Pub. L. 99–272)

(7) Outpatient dental services and treatment, and related dental appliances, for a veteran who is a former prisoner of war and was detained or interned for a period of not less that 181 days.

(Authority: 38 U.S.C. 1703; sec. 19012, Pub. L. 99–272)

(8) Hospital care or medical services for the treatment of medical emergencies which pose a serious threat to the life or health of a veteran which developed during authorized travel to the hospital, or during authorized travel

after hospital discharge preventing completion of travel to the originally designated point of return (and this will encompass any other medical services necessitated by the emergency, including extra ambulance or other transportation which may also be furnished at VA expense.

(Authority: 38 U.S.C. 1701(5))

(9) Diagnostic services necessary for determination of eligibility for, or of the appropriate course of treatment in connection with, furnishing medical services at independent VA outpatient clinics to obviate the need for hospital admission.

(Authority: 38 U.S.C. 1703; sec. 19012, Pub. L. 99–272)

(10) For any disability of a veteran receiving VA contract nursing home care. The veteran is receiving contract nursing home care and requires emergency treatment in non–VA facilities.

(Authority: 38 U.S.C. 1703(a))

(11) For completion of evaluation for observation and examination (O&E) purposes, clinic directors or their designees will authorize necessary diagnostic services at non–VA facilities (on an inpatient or outpatient basis) in order to complete requests from VA Regional Offices for O&E of a person to determine eligibility for VA benefits or services.

(b) The Under Secretary for Health shall only furnish care and treatment under paragraph (a) of this section to veterans described in §17.47(d).

(1) To the extent that resources are available and are not otherwise required to assure that VA can furnish needed care and treatment to veterans described in §17.47 (a) and (c), and

(2) If the veteran agrees to pay the United States an amount as determined in §17.48(e).

(Authority: 38 U.S.C. 1703, 1710 and 1712; sec. 19011–19012, Pub. L. 99–272)

[51 FR 25066, July 10, 1986, as amended at 53 FR 32391, Aug. 25, 1988; 54 FR 53057, Dec. 27, 1989; 58 FR 32446, June 10, 1993. Redesignated and amended at 61 FR 21965, 21966, May 13, 1996; 62 FR 17072, Apr. 9, 1997]

### §17.53 Limitations on use of public or private hospitals.

The admission of any patient to a private or public hospital at Department of Veterans Affairs expense will only be authorized if a Department of Veterans Affairs medical center or other Federal facility to which the patient would otherwise be eligible for admission is not feasibly available. A Department of Veterans Affairs facility may be considered as not feasibly available when the urgency of the applicant's medical condition, the relative distance of the travel involved, or the nature of the treatment required makes it necessary or economically advisable to use public or private facilities. In those instances where care in public or private hospitals at Department of Veterans Affairs expense is authorized because a Department of Veterans Affairs or other Federal facility was not feasibly available, as defined in this section, the authorization will be continued after admission only for the period of time required to stabilize or improve the patient's condition to the extent that further care is no longer required to satisfy the purpose for which it was initiated.

[39 FR 17223, May 14, 1974, as amended at 47 FR 58248, Dec. 30, 1982. Redesignated at 61 FR 21965, May 13, 1996]

### §17.54 Necessity for prior authorization.

(a) The admission of a veteran to a non-Department of Veterans Affairs hospital at Department of Veterans Affairs expense must be authorized in advance. In the case of an emergency which existed at the time of admission, an authorization may be deemed a prior authorization if an application, whether formal or informal, by telephone, telegraph or other communication, made by the veteran or by others in his or her behalf is dispatched to the Department of Veterans Affairs (1) for veterans in the 48 contiguous States and Puerto Rico, within 72 hours after the hour of admission, including in the computation of time Saturday, Sunday and holidays, or (2) for veterans in a noncontiguous State, territory or possession of the United States (not including Puerto Rico) if facilities for dispatch of application as described in

this section are not available within the 72-hour period, provided the application was filed within 72 hours after facilities became available.

(b) When an application for admission by a veteran in one of the 48 contiguous States in the United States or in Puerto Rico has been made more than 72 hours after admission, or more than 72 hours after facilities are available in a noncontiguous State, territory of possession of the United States, authorization for continued care at Department of Veterans Affairs expense shall be effective as of the postmark or dispatch date of the application, or the date of any telephone call constituting an informal application.

[42 FR 55212, Oct. 14, 1977. Redesignated at 61 FR 21965, May 13, 1996]

### § 17.55 Payment for authorized public or private hospital care.

Except as otherwise provided in this section, payment for public or private hospital care authorized under 38 U.S.C. 1703 and 38 CFR 17.52 of this part or under 38 U.S.C. 1728 and 38 CFR 17.120 of this part shall be based on a prospective payment system similar to that used in the Medicare program for paying for similar inpatient hospital services in the community. Payment shall be made using the Health Care Financing Administration (HCFA) PRICER for each diagnosis-related group (DRG) applicable to the episode of care.

(a) Payment shall be made of the full prospective payment amount per discharge, as determined according to the methodology in subparts D and G of 42 CFR part 412, as appropriate.

(b)(1) In the case of a veteran who was transferred to another facility before completion of care, VA shall pay the transferring hospital an amount calculated by the HCFA PRICER for each patient day of care, not to exceed the full DRG rate as provided in paragraph (a) of this section. The hospital that ultimately discharges the patient will receive the full DRG payment.

(2) In the case of a veteran who has transferred from a hospital and/or distinct part unit excluded by Medicare from the DRG-based prospective payment system or from a hospital that does not participate in Medicare, the transferring hospital will receive a payment for each patient day of care not to exceed the amount provided in paragraph (i) of this section.

(c) VA shall pay the providing facility the full DRG-based rate or reasonable cost, without regard to any copayments or deductible required by any Federal law that is not applicable to VA.

(d) If the cost or length of a veteran's care exceeds an applicable threshold amount, as determined by the HCFA PRICER program, VA shall pay, in addition to the amount payable under paragraph (a) of this section, an outlier payment calculated by the HCFA PRICER program, in accordance with subpart F of 42 CFR part 412.

(e) In addition to the amount payable under paragraph (a) of this section, VA shall pay, for each discharge, an amount to cover the non-Federal hospital's capital-related costs, kidney, heart and liver acquisition costs incurred by hospitals with approved transplantation centers, direct costs of medical education, and the costs of qualified nonphysician anesthetists in small rural hospitals. These amounts will be determined by the Under Secretary for Health on an annual basis and published in the ''Notices'' section of the FEDERAL REGISTER.

(f) Payment shall be made only for those services authorized by VA.

(g) Payments made in accordance with this section shall constitute payment in full and the provider or agent for the provider may not impose any additional charge on a veteran or his or her health care insurer for any inpatient services for which payment is made by the VA.

(h) Hospitals of distinct part hospital units excluded from the prospective payment system by Medicare and hospitals that do not participate in Medicare will be paid at the national cost-to-charge ratio times the billed charges that are reasonable, usual, customary, and not in excess of rates or fees the hospital charges the general public for similar services in the community.

(i) A hospital participating in an alternative payment system that has been granted a Federal waiver from the prospective payment system under the provisions of 42 U.S.C. section

1395f(b)(3) or 42 U.S.C. section 1395ww(c) for the purposes of Medicare payment shall not be subject to the payment methodology set forth in this section so long as such Federal waiver remains in effect.

(j) Payments for episodes of hospital care furnished in Alaska that begin during the period starting on the effective date of this section through the 364th day thereafter will be in the amount determined by the HCFA PRICER plus 50 percent of the difference between the amount billed by the hospital and the amount determined by the PRICER. Claims for services provided during that period will be accepted for payment by VA under this paragraph (k) until December 31 of the year following the year in which this section became effective.

(Authority: Section 233, Pub. L. 99–576)

[55 FR 42852, Oct. 24, 1990. Redesignated and amended at 61 FR 21965, 21966, May 13, 1996; 62 FR 17072, Apr. 9, 1997; 63 FR 39515, July 23, 1998]

USE OF COMMUNITY NURSING HOME CARE FACILITIES

### § 17.56 Payment for non-VA physician services associated with outpatient and inpatient care provided at non-VA facilities.

(a) Except for anesthesia services, payment for non-VA physician services associated with outpatient and inpatient care provided at non-VA facilities authorized under §17.52, or made under §17.120 of this part, shall be the lesser of the amount billed or the amount calculated using the formula developed by the Department of Health & Human Services, Health Care Financing Administration (HCFA) under Medicare's participating physician fee schedule for the period in which the service is provided (see 42 CFR Parts 414 and 415). This payment methodology is set forth in paragraph (b) of this section. If no amount has been calculated under Medicare's participating physician fee schedule or if the services constitute anesthesia services, payment for such non-VA physician services associated with outpatient and inpatient care provided at non-VA facilities authorized under §17.52, or made under §17.120 of this part, shall be the lesser of the actual amount billed or the amount calculated using the 75th percentile methodology set forth in paragraph (c) of this section; or the usual and customary rate if there are fewer than 8 treatment occurrences for a procedure during the previous fiscal year.

(b) The payment amount for each service paid under Medicare's participating physician fee schedule is the product of three factors: a nationally uniform relative value for the service; a geographic adjustment factor for each physician fee schedule area; and a nationally uniform conversion factor for the service. The conversion factor converts the relative values into payment amounts. For each physician fee schedule service, there are three relative values: An RVU for physician work; an RVU for practice expense; and an RVU for malpractice expense. For each of these components of the fee schedule, there is a geographic practice cost index (GPCI) for each fee schedule area. The GPCIs reflect the relative costs of practice expenses, malpractice insurance, and physician work in an area compared to the national average. The GPCIs reflect the full variation from the national average in the costs of practice expenses and malpractice insurance, but only one-quarter of the difference in area costs for physician work. The general formula calculating the Medicare fee schedule amount for a given service in a given fee schedule area can be expressed as: Payment = [(RVUwork × GPCIwork) + (RVUpractice expense × GPCIpractice expense) + (RVUmalpractice × GPCImalpractice)] × CF.

(c) Payment under the 75th percentile methodology is determined for each VA medical facility by ranking all occurrences (with a minimum of eight) under the corresponding code during the previous fiscal year with charges ranked from the highest rate billed to the lowest rate billed and the charge falling at the 75th percentile as the maximum amount to be paid.

(d) Payments made in accordance with this section shall constitute payment in full. Accordingly, the provider or agent for the provider may not impose any additional charge for any

services for which payment is made by VA.

[63 FR 39515, July 23, 1998]

### § 17.57 Use of community nursing homes.

(a) Nursing home care in a contract public or private nursing home facility may be authorized for the following: Any veteran who has been discharged from a hospital under the direct jurisdiction of VA and is currently receiving VA hospital based home health services.

(Authority: 38 U.S.C. 1720; sec. 108, Pub. L. 99–166)

(b) To the extent that resources are available and are not otherwise required to assure that VA can furnish needed care and treatment to veterans described in 38 U.S.C. 1710(a)(1), the Under Secretary for Health may furnish care under this paragraph to any veteran described in 38 U.S.C. 1710(a)(2) if the veteran agrees to pay the United States an amount as determined in 38 U.S.C. 1710(f).

(Authority: 38 U.S.C. 1710, 1720; sec. 19011, Pub. L. 99–272)

(Authority: 38 U.S.C. 1720(b)

[51 FR 25067, July 10, 1986. Redesignated and amended at 61 FR 21965, 21966, May 13, 1996 and further redesignated at 63 FR 39515, July 23, 1998]

### § 17.60 Extensions of community nursing home care beyond six months.

Directors of health care facilities may authorize, for any veteran whose hospitalization was not primarily for a service-connected disability, an extension of nursing care in a public or private nursing home care facility at VA expense beyond six months when the need for nursing home care continues to exist and

(a) Arrangements for payment of such care through a public assistance program (such as Medicaid) for which the veteran has applied, have been delayed due to unforeseen eligibility problems which can reasonably be expected to be resolved within the extension period, or

(b) The veteran has made specific arrangements for private payment for such care, and

(1) Such arrangements cannot be effectuated as planned because of unforseen, unavoidable difficulties, such as a temporary obstacle to liquidation of property, and

(2) Such difficulties can reasonably be expected to be resolved within the extension period; or

(c) The veteran is terminally ill and life expectancy has been medically determined to be less than six months.

(d) In no case may an extension under paragraph (a) or (b) of this section exceed 45 days.

(Authority: 38 U.S.C. 501, 1720(a))

[53 FR 13121, Apr. 21, 1988. Redesignated at 61 FR 21965, May 13, 1996]

## COMMUNITY RESIDENTIAL CARE

SOURCE: 54 FR 20842, May 15, 1989, unless otherwise noted.

### § 17.61 Eligibility.

VA health care personnel may assist a veteran by referring such veteran for placement in a privately or publicly-owned community residential care facility if:

(a) At the time of initiating the assistance:

(1) The veteran is receiving VA medical services on an outpatient basis or VA medical center, domiciliary, or nursing home care; or

(2) Such care or services were furnished the veteran within the preceding 12 months;

(b) The veteran does not need hospital or nursing home care but is unable to live independently because of medical (including psychiatric) conditions and has no suitable family resources to provide needed monitoring, supervision, and any necessary assistance in the veteran's daily living activities; and

(c) The facility has been approved in accordance with § 17.63 of this part.

(Authority: 38 U.S.C. 1730)

[54 FR 20842, May 15, 1989. Redesignated and amended at 61 FR 21965, 21966, May 13, 1996]

### § 17.62 Definitions.

For the purpose of §§ 17.61 through 17.72:

(a) The term *community residential care* means the monitoring, supervision, and assistance, in accordance with a statement of needed care, of the daily living activities of referred veterans in an approved home in the community by the facility's provider.

(b) The term *statement of needed care* means a written description of needed assistance in daily living activities devised by VA for each referred veteran in the community residential care program.

(c) The term *daily living activities* includes:

(1) Walking;

(2) Bathing, shaving, brushing teeth, combing hair;

(3) Dressing;

(4) Eating;

(5) Getting in or getting out of bed;

(6) Laundry;

(7) Cleaning room;

(8) Managing money;

(9) Shopping;

(10) Using public transportation;

(11) Writing letters;

(12) Making telephone calls;

(13) Obtaining appointments;

(14) Self-administration of medications;

(15) Recreational and leisure activities; and

(16) Other similar activities.

(d) The term *paper hearing* means a review of the written evidence of record by the hearing official.

(e) The term *oral hearing* means the in person testimony of representatives of a community residential care facility and of VA before the hearing official and the review of the written evidence of record by that official.

(f) The term *approving official* means the Director or, if designated by the Director, the Associate Director or Chief of Staff of a Department of Veterans Affairs Medical Center or Outpatient Clinic which has jurisdiction to approve a community residential care facility.

(g) The term *hearing official* means the Director or, if designated by the Director, the Associate Director or Chief of Staff of a Department of Veterans Affairs Medical Center or Outpatient Clinic which has jurisdiction to approve a community residential care facility.

(Authority: 38 U.S.C. 1730)

[54 FR 20842, May 15, 1989. Redesignated and amended at 61 FR 21965, 21966, May 13, 1996]

### § 17.63 Approval of community residential care facilities.

The approving official may approve a community residential care facility, based on the report of a VA inspection and on any findings of necessary interim monitoring of the facility, if that facility meets the following standards:

(a) *Health and safety standards.* The facility must:

(1) Meet all State and local regulations including construction, maintenance, and sanitation regulations;

(2) Meet the requirements of chapters 1–7, 22–23, and 31 and Appendix A of the NFPA 101, National Fire Protection Association's Life Safety Code (1994 edition), and NFPA 101A, Guide on Alternative Approaches to Life Safety (1995 edition), which are incorporated by reference. The institution shall provide sufficient staff to assist patients in the event of fire or other emergency. Incorporation by reference of these materials was approved by the Director of the Federal Register, in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. These materials incorporated by reference are available for inspection at the Office of the Federal Register, Suite 700, 800 North Capitol Street, NW., Washington, DC, and the Department of Veterans Affairs, Office of Regulations Management (02D), Room 1154, 810 Vermont Avenue, NW., Washington, DC 20420. Copies may be obtained from the National Fire Protection Association, Battery March Park, Quincy, MA 02269. (For ordering information, call toll-free 1–800–344–3555.) Any equivalencies or variances to Department of Veterans Affairs requirements must be approved by the appropriate Veterans Health Administration Veterans Integrated Service Networks (VISN) Director;

(3) Have safe and functioning systems for heating, hot and cold water, electricity, plumbing, sewage, cooking, laundry, artificial and natural light, and ventilation.

(b) *Health services.* The facility must agree to assist residents in obtaining

the statement of needed care developed by VA.

(c) *Interior plan.* The facility must:

(1) Have comfortable dining areas, adequate in size for the number of residents;

(2) Have confortable living room areas, adequate in size to accommodate a reasonable proportion of residents; and

(3) Maintain at least one functional toilet and lavatory, and bathing or shower facility for every six people living in the facility, including provider and staff.

(d) *Laundry service.* The facility must provide or arrange for laundry service.

(e) *Residents' bedrooms.* Residents' bedrooms must:

(1) Contain no more than four beds;

(2) Measure, exclusive of closet space, at least 100 square feet for a single-resident room, or 80 square feet for each resident in a multiresident room; and

(3) Contain a suitable bed for each resident and appropriate furniture and furnishings.

(f) *Nutrition.* The facility must:

(1) Provide a safe and sanitary food service that meets individual nutritional requirements and residents' preferences;

(2) Plan menus to meet currently recommended dietary allowances;

(g) *Activities.* The facility must plan and facilitate appropriate recreational and leisure activities to meet individual needs specified in the statement of heeded care.

(h) *Residents' rights.* The facility must have written policies and procedures that ensure the following rights for each resident:

(1) Each resident has the right to:

(i) Be informed of the rights described in this section;

(ii) The confidentiality and nondisclosure of information obtained by community residential care facility staff on the residents and the residents' records subject to the requirements of applicable law;

(iii) Be able to inspect the residents' own records kept by the community residential care facility;

(iv) Exercise rights as a citizen; and

(v) Voice grievances and make recommendations concerning the policies and procedures of the facility.

(2) *Financial affairs.* Residents must be allowed to manage their own personal financial affairs, except when the resident has been restricted in this right by law. If a resident requests assistance from the facility in managing personal financial affairs the request must be documented.

(3) *Privacy.* Residents must:

(i) Be treated with respect, consideration, and dignity;

(ii) Have access, in reasonable privacy, to a telephone within the facility;

(iii) Be able to send and receive mail unopened and uncensored; and

(iv) Have privacy of self and possessions.

(4) *Work.* No resident will perform household duties, other than personal housekeeping tasks, unless the resident receives compensation for these duties or is told in advance they are voluntary and the patient agrees to do them.

(5) *Freedom of association.* Residents have the right to:

(i) Receive visitors and associate freely with persons and groups of their own choosing both within and outside the facility;

(ii) Make contacts in the community and achieve the highest level of independence, autonomy, and interaction in the community of which the resident is capable;

(iii) Leave and return freely to the facility, and

(iv) Practice the religion of their own choosing or choose to abstain from religious practice.

(6) *Transfer.* Residents have the right to transfer to another facility or to an independent living situation.

(i) *Records.* (1) The facility must maintain records on each resident in a secure place.

(2) Facility records must include:

(i) A copy of the statement of needed care;

(ii) Emergency notification procedures; and

(iii) A copy of all signed agreements with the resident.

(3) Records may only be disclosed with the resident's permission, or when required by law.

(Approved by the Office of Management and Budget under control number 2900–0491)

(j) *Staff requirements.* (1) Sufficient, qualified staff must be on duty and available to care for the resident and ensure the health and safety of each resident.

(2) The community residential care provider and staff must have the following qualifications: Adequate education, training, or experience to maintain the facility.

(k) *Cost of community residential care.* (1) Payment for the charges of community residential care is not the responsibility of the United States Government or VA.

(2) The resident or an authorized personal representative and a representative of the community residential care facility must agree upon the charge and payment procedures for community residential care.

(3) The charges for community residential care must be reasonable:

(i) For residents in a community residential care facility as of June 14, 1989, the rates charged for care are pegged to the facility's basic rate for care as of July 31, 1987. Increases in the pegged rate during any calendar year cannot exceed the annual percentage increase in the National Consumer Price Index (CPI) for that year;

(ii) For community residential care facilities approved after July 31, 1987, the rates for care shall not exceed 110 percent of the average rate for approved facilities in that State as of March 31, 1987. Increases in this rate during any calendar year cannot exceed the annual percentage increase in the National Consumer Price Index (CPI) for that year.

(iii) The approving official may approve a deviation from the requirements of paragraphs (k)(3)(i) through (ii) of this section upon request from a community residential care facility representative, a resident in the facility, or an applicant for residency, if the approving official determines that the cost of care for the resident will be greater than the average cost of care for other residents, or if the resident chooses to pay more for the care provided at a facility which exceeds VA standards.

(Authority: 38 U.S.C. 1730)

[54 FR 20842, May 15, 1989, as amended at 54 FR 22754, May 26, 1989. Redesignated at 61 FR 21965, May 13, 1996, as amended at 61 FR 63720, Dec. 2, 1996]

### § 17.64 Exceptions to standards in community residential care facilities.

(a) Facilities which have participated in VA's community residential care program prior to (the effective date of these regulations) may continue to be approved when the standard for § 17.63(c)(3) and/or § 17.63(e)(2) of this part are not met if:

(1) All standards other than § 17.63(c)(3) and/or § 17.63(e)(2) of this part are met;

(2) There is at least one functional toilet, lavatory, and bathing or shower facility for every eight people living in the facility, including provider and staff;

(3) The resident's bedrooms measure, exclusive of closet space, at least 80 square feet for a single-resident room, or 65 square feet for each resident in a multiresident room.

(b) Community residential care facilities which do not meet the requirements for continued approval because they do not comply with paragraphs (a)(2) or (a)(3) of this section may apply in writing to the Secretary of Veterans Affairs for an exception. The application must include a detailed description of the facility, including a description of the toilet, lavatory and bathing and shower facilities and/or resident's bedroom size, and an analysis of alternative solutions.

(Authority: 38 U.S.C. 1730)

[54 FR 20842, May 15, 1989. Redesignated and amended at 61 FR 21965, 21967, May 13, 1996]

### § 17.65 Duration of approval.

(a) Approval may be valid for up to 24 months if VA finds that the facility complies with all standards during the current and all previous VA inspections and any necessary interim monitoring for a period of two years.

(b) Approval may be valid for up to 15 months if VA finds the facility has complied with all standards except the records standard set forth in §17.51j(i) of this part during the current and all previous VA inspections and any necessary interim monitoring.

(c) Approval may be valid for up to 12 months if the VA finds that the facility has complied with all standards except the laundry service standard set forth in §17.63(d) and the records standard set forth in §17.63(i) of this part during the current and all previous VA inspections and any necessary interim monitoring.

(d) Approval may be valid for up to 9 months if the VA finds that the facility has complied with all standards except the laundry service standard set forth in §17.63(d) of this part; the bedroom standard set forth in §17.63(e) of this part; the activities standard set forth in §17.63(g) of this part; and the records standard set forth in §17.63(i) of this part during the current and all previous VA inspections and any necessary interim monitoring.

(Authority: 38 U.S.C. 1730)

[54 FR 20842, May 15, 1989. Redesignated and amended at 61 FR 21965, 21967, May 13, 1996]

### §17.66 Notice of noncompliance with VA standards.

If the hearing official determines that an approved community residential care facility does not comply with the standards set forth in §17.63 of this part, the hearing official shall notify the community residential care facility in writing of:

(a) The standards which have not been met;

(b) The date by which the standards must be met in order to avoid revocation of VA approval;

(c) The community residential care facility's opportunity to request an oral or paper hearing under §17.51n of this part before VA approval is revoked; and

(d) The date by which the hearing official must receive the community residential care facility's request for a hearing, which shall not be less than 10 calendar days and not more than 20 calendar days after the date of VA notice of noncompliance, unless the hearing official determines that noncompliance with the standards threatens the lives of community residential care residents in which case the hearing official must receive the community residential care facility's request for an oral or paper hearing within 36 hours of receipt of VA notice.

(Authority: 38 U.S.C. 1730)

[54 FR 20842, May 15, 1989. Redesignated and amended at 61 FR 21965, 21967, May 13, 1996]

### §17.67 Request for a hearing.

The community residential care facility operator must specify in writing whether an oral or paper hearing is requested. The request for the hearing must be sent to the hearing official. Timely receipt of a request for a hearing will stay the revocation of VA approval until the hearing official issues a written decision on the community residential care facility's compliance with VA standards. The hearing official may accept a request for a hearing received after the time limit, if the community residential care facility shows that the failure of the request to be received by the hearing official's office by the required date was due to circumstances beyond its control.

(Authority: 38 U.S.C. 1730)

[54 FR 20842, May 15, 1989. Redesignated at 61 FR 21965, May 13, 1996]

### §17.68 Notice and conduct of hearing.

(a) Upon receipt of a request for an oral hearing, the hearing official shall:

(1) Notify the community residential care facility operator of the date, time, and location for the hearing; and

(2) Notify the community residential care facility operator that written statements and other evidence for the record may be submitted to the hearing official before the date of the hearing. An oral hearing shall be informal. The rules of evidence shall not be followed. Witnesses shall testify under oath or affirmation. A recording or transcript of every oral hearing shall be made. The hearing official may exclude irrelevant, immaterial, or unduly repetitious testimony.

(b) Upon the receipt of a community residential care facility's request for a paper hearing, the hearing official shall notify the community residential care facility operator that written

statements and other evidence must be submitted to the hearing official by a specified date in order to be considered as part of the record.

(c) In all hearings, the community residential care facility operator and VA may be represented by counsel.

(Authority: 38 U.S.C. 1730)

[54 FR 20842, May 15, 1989. Redesignated at 61 FR 21965, May 13, 1996]

### § 17.69 Waiver of opportunity for hearing.

If representatives of a community residential care facility which receive a notice of noncompliance under § 17.66 of this part fail to appear at an oral hearing of which they have been notified or fail to submit written statements for a paper hearing in accordance with § 17.68 of this part, unless the hearing official determines that their failure was due to circumstances beyond their control, the hearing official shall:

(a) Consider the representatives of the community residential care facility to have waived their opportunity for a hearing; and,

(b) Revoke VA approval of the community residential care facility and notify the community residential care facility of this revocation.

(Authority: 38 U.S.C. 1730)

[54 FR 20842, May 15, 1989. Redesignated and amended at 61 FR 21965, 21967, May 13, 1996]

### § 17.70 Written decision following a hearing.

(a) The hearing official shall issue a written decision within 20 days of the completion of the hearing. An oral hearing shall be considered completed when the hearing ceases to receive in person testimony. A paper hearing shall be considered complete on the date by which written statements must be submitted to the hearing official in order to be considered as part of the record.

(b) The hearing official's determination of a community residential care facility's noncompliance with VA standards shall be based on the preponderance of the evidence.

(c) The written decision shall include:

(1) A statement of the facts;

(2) A determination whether the community residential care facility complies with the standards set forth in § 17.63 of this part; and

(3) A determination of the time period, if any, the community residential care facility shall have to remedy any noncompliance with VA standards before revocation of VA approval occurs.

(d) The hearing official's determination of any time period under paragraph (c)(3) of this section shall consider the safety and health of the residents of the community residential care facility and the length of time since the community residential care facility received notice of the noncompliance.

(Authority: 38 U.S.C. 1730)

[54 FR 20842, May 15, 1989. Redesignated and amended at 61 FR 21965, 21967, May 13, 1996]

### § 17.71 Revocation of VA approval.

(a) If a hearing official determines under § 17.70 of this part that a community residential care facility does not comply with the standards set forth in § 17.63 of this part and determines that the community residential care facility shall not have further time to remedy the noncompliance, the hearing official shall revoke approval of the community residential care facility and notify the community residential care facility of this revocation.

(b) Upon revocation of VA approval, VA health care personnel shall:

(1) Cease referring veterans to the community residential care facility; and,

(2) Notify any veteran residing in the community residential care facility of the facility's disapproval and request permission to assist in the veteran's removal from the facility. If a veteran has a person or entity authorized by law to give permission on behalf of the veteran, VA health care personnel shall notify that person or entity of the community residential care facility's disapproval and request permission to assist in removing the veteran from the community residential care facility.

(c) If the hearing official determines that a community residential care facility fails to comply with the standards set forth in § 17.63 of this part and

determines that the community residential care facility shall have an additional time period to remedy the noncompliance, the hearing official shall review at the end of the time period the evidence of the community residential care facility's compliance with the standards which were to have been met by the end of that time period and determine if the community residential care facility complies with the standards. If the community residential care facility fails to comply with these or any other standards, the procedures set forth in §§17.66–17.71 of this part shall be followed.

(Authority: 38 U.S.C. 1730)

[54 FR 20842, May 15, 1989. Redesignated and amended at 61 FR 21965, 21967, May 13, 1996]

### § 17.72 Availability of information.

VA standards will be made available to other Federal, State and local agencies charged with the responsibility of licensing, or otherwise regulating or inspecting community residential care facilities.

(Authority: 38 U.S.C. 1730)

[54 FR 20842, May 15, 1989. Redesignated at 61 FR 21965, May 13, 1996]

## USE OF SERVICES OF OTHER FEDERAL AGENCIES

### § 17.80 Alcohol and drug dependence or abuse treatment and rehabilitation in residential and nonresidential facilities by contract.

(a) Alcohol and drug dependence or abuse treatment and rehabilitation may be authorized by contract in nonresidential facilities and in residential facilities provided by halfway houses, therapeutic communities, psychiatric residential treatment centers and other community-based treatment facilities, when considered to be medically advantageous and cost effective for the following:

(1) Veterans who have been or are being furnished care by professional staff over which the Secretary has jurisdiction and such transitional care is reasonably necessary to continue treatment;

(2) Persons in the Armed Forces who, upon discharge therefrom will become eligible veterans, when duly referred with authorization for Department of Veterans Affairs medical center hospital care in preparation for treatment and rehabilitation in this program under the following limitations:

(i) Such persons may be accepted by transfer only during the last 30 days of such person's enlistment or tour of duty,

(ii) The person requests transfer in writing for treatment for a specified period of time during the last 30 days of such person's enlistment period or tour of duty,

(iii) Treatment does not extend beyond the period of time specified in the request unless such person requests in writing an extension for a further specified period of time and such request is approved by the Department of Veterans Affairs Medical Center Director authorizing treatment and rehabilitation,

(iv) Such care and treatment will be provided as if the person were a veteran, subject to reimbursement by the respective military service for the costs of hospital care and control treatment provided while the person is an active duty member.

(b) The maximum period for one treatment episode is limited to 60 days. The Department of Veterans Affairs Medical Center Director may authorize one 30-day extension.

(c) Any person who has been discharged or released from active military, naval or air service, and who, upon application for treatment and rehabilitative services under the authority of this section is determined to be legally ineligible for such treatment or rehabilitation services shall be:

(1) Provided referral services to assist the person, to the maximum extent possible, in obtaining treatment and rehabilitation services from sources outside the Department of Veterans Affairs, not at Department of Veterans Affairs expense and,

(2) If pertinent, advised of the right to apply to the appropriate military, naval or air service and the Department of Veterans Affairs for review of

such person's discharge or release from such service.

(Authority: 38 U.S.C. 1720A)

[47 FR 57706, Dec. 28, 1982. Redesignated at 61 FR 21965, May 13, 1996, as amended at 61 FR 56897, Nov. 5, 1996]

### § 17.81 Contracts for residential treatment services for veterans with alcohol or drug dependence or abuse disabilities.

(a) Contracts for treatment services authorized under §17.80(a) may be awarded in accordance with applicable Department of Veterans Affairs and Federal procurement procedures. Such contracts will be awarded only after the quality and effectiveness, including adequate protection for the safety of the residents of the contractor's program, has been determined and then only to contractors, determined by the Under Secretary for Health or designee to meet the following requirements.

(1) Meet fire safety requirements as follows:

(i) The building must meet the requirements of the applicable residential occupancy chapters (1–7, 22–23, and 31) and Appendix A of the NFPA 101, National Fire Protection Association's Life Safety Code (1994 edition) which are incorporated by reference. Incorporation by reference of these materials was approved by the Director of the Federal Register, in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. These materials incorporated by reference are available for inspection at the Office of the Federal Register, Suite 700, 800 North Capitol Street, NW., Washington, DC, and the Department of Veterans Affairs, Office of Regulations Management (02D), Room 1154, 810 Vermont Avenue, NW., Washington, DC 20420. Copies may be obtained from the National Fire Protection Association, Battery March Park, Quincy, MA 02269. (For ordering information, call toll-free 1–800–344–3555.) Any equivalencies or variances to Department of Veterans Affairs requirements must be approved by the appropriate Veterans Health Administration Veterans Integrated Service Networks (VISN) Director.

(ii) Where applicable, the home must have a current occupancy permit issued by the local and state governments in the jurisdiction where the home is located.

(iii) All Department of Veterans Affairs sponsored residents will be mentally and physically capable of leaving the building, unaided, in the event of an emergency. Halfway house, therapeutic community and other residential program management must agree that all the other residents in any building housing veterans will also have such capability.

(iv) There must be at least one staff member on duty 24 hours a day.

(v) Fire exit drills must be held at least quarterly. Residents must be instructed in evacuation procedures when the primary and/or secondary exits are blocked. A written fire plan for evacuation in the event of fire shall be developed and reviewed annually. The plan shall outline the duties, responsibilities and actions to be taken by the staff and residents in the event of a fire emergency. This plan shall be implemented during fire exit drills.

(vi) A written policy regarding tobacco smoking in the facility shall be established and enforced.

(vii) Portable fire extinguishers shall be installed at the facility. Use NFPA 10, *Portable Fire Extinguishers,* as guidance in selection and location requirements of extingushers.

(viii) Requirements for fire protection equipment and systems shall be in accordance with NFPA 101. Where installed, maintenance and testing of these systems/equipment shall include the following:

(A) The fire alarm system shall be test operated at least semi-annually.

(B) All smoke detectors shall be test operated, by activation of the smoke detector, at least semi-annually.

(C) The monthly and annual inspections and the maintenance of the extinguishers shall be in accordance with NFPA 10.

(D) All fire protection systems and equipment, such as the fire alarm system, smoke detectors, and portable extinguishers, shall be inspected, tested and maintained in accordance with the applicable NFPA fire codes and the results documented.

(ix) An annual fire and safety inspection shall be conducted at the halfway

house or residential facility by qualified Department of Veterans Affairs personnel. If a review of past Department of Veterans Affairs inspections or inspections made by the local authorities indicates that a fire and safety inspection would not be necessary, then the visit to the facility may be waived.

(2) Be in compliance with existing standards of State safety codes and local, and/or State health and sanitation codes.

(3) Be licensed under State or local authority.

(4) Where applicable, be accredited by the State.

(5) Comply with the requirements of the ''Confidentiality of Alcohol and Drug Abuse Patient Records'' (42 CFR part II) and the ''Confidentiality of Certain Medical Records'' (38 U.S.C. 7332), which shall be part of the contract.

(6) Demonstrate an existing capability to furnish the following:

(i) A supervised alcohol and drug free environment, including active affiliation with Alcoholics Anonymous (AA) programs.

(ii) Staff sufficient in numbers and position qualifications to carry out the policies, responsibilities, and programs of the facility.

(iii) Board and room.

(iv) Laundry facilities for residents to do their own laundry.

(v) Structured activities.

(vi) Appropriate group activities, including physical activities.

(vii) Health and personal hygiene maintenance.

(viii) Monitoring administration of medications.

(ix) Supportive social service.

(x) Individual counseling as appropriate.

(xi) Opportunities for learning/development of skills and habits which will enable Department of Veterans Affairs sponsored residents to adjust to and maintain freedom from dependence on or involvement with alcohol or drug abuse or dependence during or subsequent to leaving the facility.

(xii) Support for the individual desire for sobriety (alcohol/drug abuse-free life style).

(xiii) Opportunities for learning, testing, and internalizing knowledge of illness/recovery process, and for upgrading skills and improving personal relationships.

(7) Data normally maintained and included in a medical record as a function of compliance with State or community licensing standards will be accessible.

(b) Representatives of the Department of Veterans Affairs will inspect the facility prior to award of a contract to assure that prescribed requirements can be met. Inspections may also be carried out at such other times as deemed necessary by the Department of Veterans Affairs.

(c) All requirements in this rule, and Department of Veterans Affairs reports of inspection of residential facilities furnishing treatment and rehabilitation services to eligible veterans shall to the extent possible, be made available to all government agencies charged with the responsibility of licensing or otherwise regulating or inspecting such institutions.

(d) An individual case record will be created for each client which shall be maintained in security and confidence as required by the ''Confidentiality of Alcohol and Drug Abuse Patient Records'' (42 CFR part 2) and the ''Confidentiality of Certain Medical Records'' (38 U.S.C. 7332), and will be made available on a need to know basis to appropriate Department of Veterans Affairs staff members involved with the treatment program of the veterans concerned.

(e) Contractors under this section shall provide reports of budget and case load experience upon request from a Department of Veterans Affairs official.

(Authority: 38 U.S.C. 1720A)

[47 FR 57707, Dec. 28, 1982. Redesignated and amended at 61 FR 21965, 21967, May 13, 1996; 61 FR 63720, Dec. 2, 1996]

### § 17.82 Contracts for outpatient services for veterans with alcohol or drug dependence or abuse disabilities.

(a) Contracts for treatment services authorized under § 17.80 may be awarded in accordance with applicable Department of Veterans Affairs and Federal procurement procedures. Such contracts will be awarded only after

the quality and effectiveness, including adequate protection for the safety of the participants of the contractor's program, has been determined and then only to contractors determined by the Under Secretary for Health or designee to be fully capable of meeting the following standards:

(1) The following minimum fire safety requirements must be met:

(i) The building must meet the requirements of the applicable business occupancy chapters (1–7, 26–27, and 31) and Appendix A of the NFPA 101, National Fire Protection Association's Life Safety Code (1994 edition) which are incorporated by reference. Incorporation by reference of these materials was approved by the Director of the Federal Register, in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. These materials incorporated by reference are available for inspection at the Office of the Federal Register, Suite 700, 800 North Capitol Street, NW., Washington, DC, and the Department of Veterans Affairs, Office of Regulations Management (02D), Room 1154, 810 Vermont Avenue, NW., Washington, DC 20420. Copies may be obtained from the National Fire Protection Association, Battery March Park, Quincy, MA 02269. (For ordering information, call toll-free 1–800–344–3555.) Any equivalencies or variances to Department of Veterans Affairs requirements must be approved by the appropriate Veterans Health Administration Veterans Integrated Service Networks (VISN) Director.

(ii) Where applicable, the facility must have a current occupancy permit issued by the local and state governments in the jurisdiction where the home is located.

(iii) All Department of Veterans Affairs sponsored patients will be mentally and physically capable of leaving the building, unaided, in the event of an emergency.

(iv) Fire exit drills must be held at least quarterly. A written plan for evacuation in the event of fire shall be developed and reviewed annually. The plan shall outline the duties, responsibilities and actions to be taken by the staff in the event of a fire emergency. This plan shall be implemented during fire exit drills.

(v) Portable fire extinguishers shall be installed at the facility. Use NFPA 10, *Portable Fire Extinguishers,* as guidance in selection and location requirements of extinguishers.

(vi) Requirements for fire protection equipment and systems shall be in accordance with NFPA 101. Where installed, maintenance and testing of these systems/equipment shall include the following:

(A) The fire alarm system shall be test operated at least semi-annually.

(B) All smoke detectors shall be test operated, by activation of the smoke detector, at least sem-annually.

(C) The monthly and annual inspections and the maintenance of the extinguishers shall be in accordance with NFPA 10.

(D) All fire protection systems and equipment, such as the fire alarm system, smoke detectors, and portable extinguishers, shall be inspected, tested and maintained in accordance with the applicable NFPA fire codes and the results documented.

(vii) An annual fire and safety inspection shall be conducted at the facility by qualified Department of Veterans Affairs personnel. If a review of past Department of Veterans Affairs inspections or inspections made by the local authorities indicates that a fire and safety inspection would not be necessary, then the visit to the facility may be waived.

(2) Conform to existing standards of State safety codes and local and/or State health and sanitation codes.

(3) Be licensed under State or local authority.

(4) Where applicable, be accredited by the State.

(5) Comply with the requirements of the ''Confidentiality of Alcohol and Drug Abuse Patient Records'' (42 CFR part 2) and the ''Confidentiality of Certain Medical Records'' (38 U.S.C. 7332), which shall be part of the contract.

(6) Demonstrate an existing capability to furnish the following:

(i) A supervised, alcohol and drug free environment, including active affiliation with Alcoholics Anonymous (AA) programs.

(ii) Staff sufficient in numbers and position qualifications to carry out the

policies, responsibilities, and programs of the facility.

(iii) Structured activities.

(iv) Appropriate group activities.

(v) Monitoring medications.

(vi) Supportive social service.

(vii) Individual counseling as appropriate.

(viii) Opportunities for learning/development of skills and habits which will enable Department of Veterans Affairs sponsored residents to adjust to and maintain freedom from dependence on or involvement with alcohol or drug abuse or dependence during or subsequent to leaving the facility.

(ix) Support for the individual desire for sobriety (alcohol/drug abuse-free life style).

(x) Opportunities for learning, testing, and internalizing knowledge of illness/recovery process, and to upgrade skills and improve personal relationships.

(7) Data normally maintained and included in a medical record as a function of compliance with State or community licensing standards will be accessible.

(b) Representatives of the Department of Veterans Affairs will inspect the facility prior to award of a contract to assure that prescribed requirements can be met. Inspections may also be carried out at such other times as deemed necessary by the Department of Veterans Affairs.

(c) All requirements in this rule and Department of Veterans Affairs reports of inspection of residential facilities furnishing treatment and rehabilitation services to eligible veterans shall, to the extent possible, be made available to all government agencies charged with the responsibility of licensing or otherwise regulating or inspecting such institutions.

(d) An individual case record will be created for each client which shall be maintained in security and confidence as required by the ''Confidentiality of Alcohol and Drug Abuse Patient Records'' (42 CFR part 2) and the ''Confidentiality of Certain Medical Records'' (38 U.S.C. 7332), and will be made available on a need to know basis to appropriate Department of Veterans Affairs staff members involved with the treatment program of the veterans concerned.

(Authority: 38 U.S.C. 1720A)

[47 FR 57708, Dec. 28, 1982. Redesignated and amended at 61 FR 21965, 21967, May 13, 1996; 61 FR 63720, Dec. 2, 1996; 62 FR 17072, Apr. 9, 1997]

### § 17.83 Limitations on payment for alcohol and drug dependence or abuse treatment and rehabilitation.

The authority to enter into contracts shall be effective for any fiscal year only to such extent or in such amounts as are provided in appropriation acts, and payments shall not exceed these amounts.

(Authority: Pub. L. 96–22, 38 U.S.C. 1720A)

[47 FR 57708, Dec. 28, 1982. Redesignated at 61 FR 21965, May 13, 1996]

## RESEARCH-RELATED INJURIES

### § 17.85 Treatment of research-related injuries to human subjects.

(a) VA medical facilities shall provide necessary medical treatment to a research subject injured as a result of participation in a research project approved by a VA Research and Development Committee and conducted under the supervision of one or more VA employees. This section does not apply to:

(1) Treatment for injuries due to noncompliance by a subject with study procedures, or

(2) Research conducted for VA under a contract with an individual or a non-VA institution.

NOTE TO §17.85(a)(1) AND (a)(2): Veterans who are injured as a result of participation in such research may be eligible for care from VA under other provisions of this part.

(b) Except in the following situations, care for VA research subjects under this section shall be provided in VA medical facilities.

(1) If VA medical facilities are not capable of furnishing economical care or are not capable of furnishing the care or services required, VA medical facility directors shall contract for the needed care.

(2) If inpatient care must be provided to a non-veteran under this section, VA medical facility directors may contract for such care.

(3) If a research subject needs treatment in a medical emergency for a condition covered by this section, VA medical facility directors shall provide reasonable reimbursement for the emergency treatment in a non-VA facility.

(c) For purposes of this section, ''VA employee'' means any person appointed by VA as an officer or employee and acting within the scope of his or her appointment (VA appoints officers and employees under title 5 and title 38 of the United States Code).

(Authority: 38 U.S.C. 501, 7303)

[63 FR 11124, Mar. 6, 1998]

VOCATIONAL TRAINING AND HEALTH-CARE ELIGIBILITY PROTECTION FOR PENSION RECIPIENTS

### § 17.90 Medical care for veterans receiving vocational training under 38 U.S.C. chapter 15.

Hospital care, nursing home care and medical services may be provided to any veteran who is participating in a vocational training program under 38 U.S.C. chapter 15.

(a) For purposes of determining eligibility for this medical benefit, the term *participating in a vocational training program under 38 U.S.C. chapter 15* means the same as the term *participating in a rehabilitation program under 38 U.S.C. chapter 31* as defined in §17.47(j). Eligibility for such medical care will continue only while the veteran is participating in the vocational training program.

(b) The term *hospital care and medical services* means class V dental care, priority III medical services, nursing home care and non-VA hospital care and/or fee medical/dental care if VA is unable to provide the required medical care economically at VA or other government facilities because of geographic inaccessibility or because of the unavailability of the required services at VA facilities.

(Authority: 38 U.S.C. 1524, 1525, 1516)

[51 FR 19330, May 29, 1986, as amended at 56 FR 3422, Jan. 30, 1991. Redesignated and amended at 61 FR 21965, 21967, May 13, 1996]

### § 17.91 Protection of health-care eligibility.

Any veteran whose entitlement to VA pension is terminated by reason of income from work or training shall, subject to paragraphs (a) and (b) of this section, retain for 3 years after the termination, the eligibility for hospital care, nursing home care and medical services (not including dental) which the veteran otherwise would have had if the pension had not been terminated as a result of the veteran's receipt of earnings from activity performed for remuneration or gain by the veteran but only if the veteran's annual income from sources other than such earnings would, taken alone, not result in the termination of the veteran's pension.

(a) A veteran who participates in a vocational training program under 38 U.S.C. chapter 15 is eligible for the one-time 3 year retention of hospital care, nursing home care and medical services benefits at any time that the veteran's pension is terminated by reason of income from the veteran's employment.

(b) A veteran who does not participate in a vocational training program under 38 U.S.C. chapter 15 is eligible for the one-time 3 year retention of hospital care and medical services benefits only if the veteran's pension is terminated by reason of income from the veteran's employment during the period February 1, 1985 through January 31, 1989.

(Authority: 38 U.S.C. 1524, 1525, 1516)

[51 FR 19330, May 29, 1986. Redesignated at 61 FR 21965, May 13, 1996]

OUTPATIENT TREATMENT

### § 17.92 Outpatient care for research purposes.

Subject to the provisions of §17.101, any person who is a bona fide volunteer may be furnished outpatient treatment when the treatment to be rendered is part of an approved Department of Veterans Affairs research project and there are insufficient veteran-patients suitable for the project.

[35 FR 11470, July 17, 1970. Redesignated and amended at 61 FR 21965, 21967, May 13, 1996]

### § 17.93 Eligibility for outpatient services.

(a) VA shall furnish on an ambulatory or outpatient basis medical services as are needed, to the following applicants under the conditions stated, except that applications for dental treatment must also meet the provisions of § 17.161.

(Authority: 38 U.S.C. 1712)

(1) *For compensation and pension examinations.* A compensation and pension examination shall be performed for any veteran who is directed to have such an examination by VA.(Authority: 38 U.S.C. 111 and 501)

(2) *For adjunct treatment.* Subject to the provisions of §§ 17.36 through 17.38, medical services on an ambulatory or outpatient basis shall be provided to veteans for an adjunct nonservice-connected condition associated with and held to be aggravating a disability from a disease or injury adjudicated as being service-connected.

(b) The term ''shall furnish'' in this section and 38 U.S.C. 1712 (a)(1) and (a)(2) means that, if the veteran is in immediate need of outpatient medical services, VA shall furnish care at the VA facility where the veteran applies. If the needed medical services are not available there, VA shall arrange for care at the nearest VA medical facility or Department of Defense facility (with which VA has a sharing agreement) that can provide the needed care. If VA and Department of Defense facilities are not available, VA shall arrange for care on a fee basis, but only if the veteran is eligible to receive medical services in non-VA facilities under § 17.52.

If the veteran is not in immediate need of outpatient medical services, VA shall schedule the veteran for care where the veteran applied, if the schedule there permits, or refer the veteran for scheduling to the nearest VA medical center or Department of Defense facility (with which VA has a sharing agreement).

(c) VA may furnish on an ambulatory or outpatient basis medical services as needed to the following applicants, except that applications for dental treatment must also meet the provisions of § 17.123.

(1) *For veterans participating in a rehabilitation program under 38 U.S.C. chapter 31.* Medical services on an ambulatory or outpatient basis may be provided as determined medically necessary for a veteran participating in a rehabilitation program under 38 U.S.C. chapter 31 as defined in § 17.47(j).

(2) [Reserved]

(Authority: 38 U.S.C. 1717)

[55 FR 20150, May 15, 1990, as amended at 58 FR 25565, Apr. 27, 1993. Redesignated and amended at 61 FR 21965, 21967, May 13, 1996; 64 FR 54218, Oct. 6, 1999]

### § 17.94 Outpatient medical services for military retirees and other beneficiaries.

Outpatient medical services for military retirees and other beneficiaries for which charges shall be made as required by § 17.101, may be authorized for persons properly referred by authorized officials of other Federal agencies for which the Secretary of Veterans Affairs may agree to render such service under the conditions stipulated by the Secretary and pensioners of nations allied with the United States in World War I and World War II when duly authorized.

[32 FR 13815, Oct. 4, 1967, as amended at 45 FR 6937, Jan. 31, 1980; 47 FR 58249, Dec. 30, 1982. Redesignated and amended at 61 FR 21965, 21967, May 13, 1996]

### § 17.95 Outpatient medical services for Department of Veterans Affairs employees and others in emergencies.

Outpatient medical services for which charges shall be made as required by § 17.101 may be authorized for employees of the Department of Veterans Affairs, their families, and the general public in emergencies, subject to conditions stipulated by the Secretary of Veterans Affairs.

(Authority: 38 U.S.C. 1711(c)(1))

[47 FR 58249, Dec. 30, 1982. Redesignated and amended at 61 FR 21965, 21967, May 13, 1996]

### § 17.96 Prescriptions filled.

Any prescription, which is not part of authorized Department of Veterans Affairs hospital or outpatient care, for drugs and medicines ordered by a private or non-Department of Veterans Affairs doctor of medicine or doctor of

osteopathy duly licensed to practice in the jurisdiction where the prescription is written, shall be filled by a Department of Veterans Affairs pharmacy or a non-VA pharmacy in a state home under contract with VA for filling prescriptions for patients in state homes, provided:

(a) The prescription is for:

(1) A veteran who by reason of being permanently housebound or in need of regular aid and attendance is in receipt of increased compensation under 38 U.S.C. chapter 11, or increased pension under §3.1(u) (Section 306 Pension) or §3.1(w) (Improved Pension), of this title, as a veteran of the Mexican Border Period, World War I, World War II, the Korean Conflict, or the Vietnam Era (or, although eligible for such pension, is in receipt of compensation as the greater benefit), or

(2) A veteran in need of regular aid and attendance who was formerly in receipt of increased pension as described in paragraph (a)(1) of this section whose pension has been discontinued solely by reason of excess income, but only so long as such veteran's annual income does not exceed the maximum annual income limitation by more than $1,000, and

(b) The drugs and medicines are prescribed as specific therapy in the treatment of any of the veteran's illnesses or injuries.

(Authority: 38 U.S.C. 1712 (d))

[32 FR 13816, Oct. 4, 1967, as amended at 36 FR 4782, Mar. 12, 1971; 45 FR 6937, Jan. 31, 1980; 47 FR 58249, Dec. 30, 1982. Redesignated at 61 FR 21965, May 13, 1996, as amended at 63 FR 37780, July 14, 1998]

### § 17.97 Prescriptions in Alaska, and territories and possessions.

In Alaska and territories and possessions, where there are no Department of Veterans Affairs pharmacies, the expenses of any prescriptions filled by a private pharmacist which otherwise could have been filled by a Department of Veterans Affairs pharmacy under 38 U.S.C. 1712(h), may be reimbursed.

[32 FR 13816, Oct. 4, 1967. Redesignated and amended at 61 FR 21965, 21967, May 13, 1996]

### § 17.98 Mental health services.

(a) Following the death of a veteran, bereavement counseling involving services defined in 38 U.S.C. 1701(6)(B), may be furnished to persons who were receiving mental health services in connection with treatment of the veteran under 38 U.S.C. 1710, 1712, 1712A, 1713, or 1717, or 38 CFR 17.84 of this part, prior to the veteran's death, but may only be furnished in instances where the veteran's death had been unexpected or occurred while the veteran was participating in a VA hospice or similar program. Bereavement counseling may be provided only to assist individuals with the emotional and psychological stress accompanying the veteran's death, and only for a limited period of time, as determined by the Medical Center Director, but not to exceed 60 days. The Medical Center Director may approve a longer period of time when medically indicated.

(b) For purposes of paragraph (a) of this section, an unexpected death is one which occurs when in the course of an illness the provider of care did not or could not have anticipated the timing of the death. Ordinarily, the provider of care can anticipate the patient's death and can inform the patient and family of the immediacy and certainty of death. If that has not taken place, a death can be described as unexpected.

(Authority: 38 U.S.C. 1701(6)(B))

[53 FR 7186, Mar. 7, 1988. Redesignated and amended at 61 FR 21965, 21967, May 13, 1996]

## BREAKING APPOINTMENTS

### § 17.100 Refusal of treatment by unnecessarily breaking appointments.

A patient under medical treatment who breaks an appointment without a reasonable excuse will be informed that breaking an additional appointment will be deemed to be a refusal to accept VA treatment. If such a patient fails to keep a second appointment, without at least 24 hours notice, such action will be deemed as a refusal to accept VA treatment. Thereafter, no further treatment will be furnished until the veteran has agreed to cooperate by keeping appointments. Treatment will not be discontinued until the

treating physician has reviewed the treatment files, concurred in the action and signed a statement to this effect in the record. Consideration will be given to the veteran's ability to make a rational decision concerning the need for medical care and/or examination. The veteran will be advised of the final decision. Nothing in this section will be construed to prevent treatment for an emergent condition that may arise during or subsequent to this action. Where an appointment is broken without notice and satisfactory reasons are advanced for breaking the appointment and circumstances were such that notice could not be given, the patient will not be deemed to have refused treatment.

(Authority: 38 U.S.C. 7304)

[51 FR 8672, Mar. 13, 1986. Redesignated at 61 FR 21965, May 13, 1996; 64 FR 54218, Oct. 6, 1999]

CHARGES, WAIVERS, AND COLLECTIONS

### § 17.101 Collection or recovery by VA for medical care or services provided or furnished to a veteran for a non-service connected disability.

(a)(1) *General.* This section covers collection or recovery by VA, under 38 U.S.C. 1729, for medical care or services provided or furnished to a veteran:

(i) For a non-service connected disability for which the veteran is entitled to care (or the payment of expenses of care) under a health-plan contract;

(ii) For a non-service connected disability incurred incident to the veteran's employment and covered under a worker's compensation law or plan that provides reimbursement or indemnification for such care and services; or

(iii) For a non-service connected disability incurred as a result of a motor vehicle accident in a State that requires automobile accident reparations insurance.

(2) *Methodology.* Based on the methodology set forth in this section, the charges billed will include, as appropriate, inpatient facility charges, skilled nursing facility/sub-acute inpatient facility charges, outpatient facility charges, physician charges, and non-physician provider charges. In addition, the charges billed for prosthetic devices and durable medical equipment provided on an outpatient basis will be VA's actual cost and the charges billed for prescription drugs not administered during treatment will be a single nationwide average. Data for calculating actual amounts for inpatient facility charges, skilled nursing facility/sub-acute inpatient facility charges, outpatient facility charges, and physician charges will be published annually in the ''Notices'' section of the FEDERAL REGISTER. In those cases in which the effective period for published charges has expired and new charges have not yet become effective, VA will continue to bill using the most recently published charges until new charges are published and become effective (for example, if the most recently published charges state that they are effective through December and new charges are not published and effective until February 1, then the charges set forth for the period through December will continue to be used through January 31).

(3) *Amount of recovery or collection—third party liability.* A third-party payer liable under a health-plan contract has the option of paying either the billed charges described in this section or the amount the health-plan demonstrates is the amount it would pay for care or services furnished by providers other than entities of the United States for the same care or services in the same geographic area. If the amount submitted by the health plan for payment is less than the amount billed, VA will accept the submission as payment, subject to verification at VA's discretion in accordance with this section. A VA employee having responsibility for collection of such charges may request that the third party health plan submit evidence or information to substantiate the appropriateness of the payment amount (e.g., health plan or insurance policies, provider agreements, medical evidence, proof of payment to other providers in the same geographic area for the same care and services VA provided).

(4) *Definitions.* For purposes of this section:

*Consolidated MSA* means a consolidated Metropolitan Statistical Area.

*CPI* means Consumer Price Index.

*CPI–U* means Consumer Price Index—All Urban Consumers.

*CPI–W* means Consumer Price Index—Urban Wage Earners and Clerical Workers .

*CPT procedure code* means a 5 digit-identifier for a specified physician service or procedure.

*DRG* means diagnosis related group.

*Geographic area* means Metropolitan Statistical Area (MSA) or the local market, if the VA facility is not located in an MSA.

*RVU* means relative value unit.

(b) *Inpatient facility charges.* When VA provides or furnishes inpatient services within the scope of care referred to in paragraph (a)(1) of this section, inpatient facility charges billed for such services will be determined in accordance with the provisions of this paragraph. Inpatient facility charges consist of per diem charges for room and board and for ancillary services that vary by VA facility and by DRG. These charges are calculated as follows:

(1) *Formula.* For each inpatient stay or portion thereof for which a particular DRG assignment applies, multiply the nationwide room and board per diem charge as set forth in paragraph (b)(2) of this section by the appropriate geographic area adjustment factor as set forth in paragraph (b)(3) of this section. The result constitutes the facility-specific room and board per diem charge. Also, for each inpatient stay, multiply the nationwide ancillary per diem charge as set forth in paragraph (b)(2) of this section by the appropriate geographic area adjustment factor as set forth in paragraph (b)(3) of this section. The result constitutes the facility-specific ancillary per diem charge. Then add the facility-specific room and board per diem charge to the facility-specific ancillary per diem charge. This constitutes the facility-specific combined per diem facility charge. Finally, multiply the facility-specific combined per diem facility charge by the number of days of inpatient care to obtain the total inpatient facility charge.

NOTE TO PARAGRAPH (b)(1): If there is a change in a patient's condition and/or treatment during a single inpatient stay such that the DRG assignment changes (for example, a psychiatric patient who develops a medical or surgical problem), then the calculations will be made separately for each DRG, according to the number of days of care applicable for each DRG, and the total inpatient facility charge will be the sum of the total inpatient facility charges for the different DRGs.

(2) *Per diem charges.* To establish a baseline, two nationwide average per diem charges for each DRG are calculated for Calendar Year 1995, one from the Medicare Standard Analytical File 5% Sample and one from the MedStat claim database, a claim database of nationwide commercial insurance. Results obtained from these two databases are then combined into a single weighted average per diem charge for each DRG. The resulting weighted average per diem charge for each DRG is then separated into its two components, a room and board component and an ancillary component, with the amount for each component calculated to reflect the corresponding percentage set forth in paragraph (b)(2)(i) of this section. The resulting amounts for room and board and ancillary services for each DRG are then each multiplied by the final ratio set forth in paragraph (b)(2)(ii) of this section to reflect the 80th percentile charges. Finally, the resulting charges are each trended forward from their 1995 base to the effective time period for the charges, as set forth in paragraph (b)(2)(iii) of this section. The results constitute the room and board per diem charge and the ancillary per diem charge.

(i) *Charge component percentages.* Using only those cases from the Medicare Standard Analytical File 5% Sample for which a distinction between room and board charges and ancillary charges can be determined, the percentage of the total charges for room and board compared to the combined total charges for room and board and ancillary services, and the percentage of the total charges for ancillary services compared to the combined total charges for room and board and ancillary services, are calculated by DRG.

(ii) *80th percentile.* Using the medical and surgical admissions in the Medicare Standard Analytical File 5% Sample, obtain for each consolidated MSA the ratio of the day-weighted 80th percentile semi-private room and board per diem charge to the average semi-

private room and board per diem charge. The consolidated MSA ratios are averaged to obtain a final 80th percentile ratio.

(iii) *Trending forward.* For each DRG, the 80th percentile charges, representing calculations for calendar year 1995, are trended forward for the period August 1998 through September 1999, and for each 12-month calendar year period thereafter, beginning January 1, 2000, based on changes to the CPI. The projected total CPI trend from 1995 to the midpoint of the effective charge period is calculated as the composite of three components. The first component trends from 1995 to January 1997, using the Hospital Room component of the CPI–W for room and board charges and using the Other Hospital component of the CPI–W for ancillary charges. The second component trends from January 1997 to the latest available month, based on the Inpatient Hospital component of the CPI–U for room and board and ancillary charges. The third component trends from the latest available month to the midpoint of the effective charge period, based on the latest three-month average annual trend rate from the Inpatient Hospital component of the CPI–U. The projected total CPI trends are then applied to the 1995-base 80th percentile charges.

(3) *Geographic area adjustment factors.* For each VA facility location, the average per diem room and board charges and ancillary charges from the 1995 Medicare Standard Analytical File 5% Sample are calculated for each DRG. The DRGs are separated into two groups, surgical and non-surgical. For each of these groups of DRGs, for each geographic area, average room and board per diem charges and ancillary per diem charges are calculated for 1995, weighted by FY 1997 nationwide VA discharges and by average lengths of stay from the combined Medicare Standard Analytical File 5% Sample and the MedStat claim data base. This results in four average per diem charges for each geographic area: room and board for surgical DRGs, ancillary for surgical DRGs, room and board for non-surgical DRGs, and ancillary for non-surgical DRGs. Four corresponding national average per diem charges are obtained from the 1995 Medicare Standard Analytical File 5% Sample, weighted by FY 1997 nationwide VA discharges and by average lengths of stay from the combined Medicare Standard Analytical File 5% Sample and the MedStat claim data base. Four geographic area adjustment factors are then calculated for each geographic area by dividing each geographic area average per diem charge by the corresponding national average per diem charge.

(c) *Skilled nursing facility/sub-acute inpatient facility charges.* When VA provides or furnishes skilled nursing/sub-acute inpatient services within the scope of care referred to in paragraph (a)(1) of this section, skilled nursing facility/sub-acute inpatient facility charges billed for such services will be determined in accordance with the provisions of this paragraph. The skilled nursing facility/sub-acute inpatient facility charges are per diem charges that vary by VA facility. The facility charges cover care, including skilled rehabilitation services (e.g., physical therapy, occupational therapy, and speech therapy), that is provided in a nursing home or hospital inpatient setting, is provided under a physician's orders, and is performed by or under the general supervision of professional personnel such as registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech therapists, and audiologists. The skilled nursing facility/sub-acute inpatient facility charges also incorporate charges for ancillary services associated with care provided in these settings. The charges are calculated as follows:

(1) *Formula.* For each stay, multiply the nationwide per diem charge as set forth in paragraph (c)(2) of this section by the appropriate geographic area adjustment factor as set forth in paragraph (c)(3) of this section. The result constitutes the facility-specific per diem charge. Finally, multiply the facility-specific per diem charge by the number of days of care to obtain the total skilled nursing facility/sub-acute inpatient facility charge.

(2) *Per diem charge.* To establish a baseline, a nationwide average per diem billed charge for July 1, 1998, was

obtained from the 1998 Milliman & Robertson, Inc. Health Cost Guidelines, a publication that includes nationwide skilled nursing facility charges (Milliman & Robertson, Inc., 1301 5th Ave., Suite 3800, Seattle, WA 98101–2605). That average per diem billed charge is then multiplied by the 80th percentile adjustment factor set forth in paragraph (c)(2)(i) of this section to obtain a nationwide 80th percentile charge level. Finally, the resulting charge is trended forward to the effective time period for the charges, as set forth in paragraph (c)(2)(ii) of this section.

(i) *80th percentile.* Using the 1995 Medicare Standard Analytical File 5% Sample, the median per diem accommodation charge is calculated for each provider. For each State, the ratio of the 80th percentile of provider median charges to the average statewide charges for accommodations is calculated. The State ratios are averaged to produce a nationwide 80th percentile adjustment factor.

(ii) *Trending forward.* The 80th percentile charge, representing charge levels for July 1, 1998, is trended forward to the midpoint of the period August 1998 through September 1999, and to the midpoint of each 12-month calendar year period thereafter, beginning January 1, 2000, based on the projected change in Medicare reimbursement from the Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund (this report can be found on the Health Care Financing Administration Internet site at *http://www.hcfa.gov* under the headings ''Publications and Forms'' and ''Professional/ Technical Publications'').

(3) *Geographic area adjustment factors.* A ratio of the average per diem charge for each State to the nationwide average per diem charge is obtained (these ratios are set forth in the 1998 Milliman & Robertson, Inc. Health Cost Guidelines, a data base of nationwide commercial insurance charges and relative costs) (Milliman & Robertson, Inc., 1301 5th Ave., Suite 3800, Seattle, WA 98101–2605). The geographic area adjustment factor for charges for each VA facility is the ratio for the State in which the facility is located.

(d) *Outpatient facility charges.* When VA provides or furnishes outpatient services that are within the scope of care referred to in paragraph (a)(1) of this section and are not customarily performed in an independent clinician's office, the outpatient facility charges billed for such services will be determined in accordance with the provisions of this paragraph. Except for prosthetic devices and durable medical equipment, whose charges will be made separately at actual cost to VA, charges for outpatient facility services will vary by VA facility and by CPT procedure code. These charges will be calculated as follows:

(1) *Formula.* For each outpatient facility charge CPT procedure code, multiply the nationwide charge as set forth in paragraph (d)(2) of this section by the appropriate geographic area adjustment factor as set forth in paragraph (d)(4) of this section. The result constitutes the facility-specific outpatient facility charge. When multiple surgical procedures are performed during the same outpatient encounter by a provider or provider team, the outpatient facility charges for such procedures will be reduced as set forth in paragraph (d)(5) of this section.

(2) *Nationwide 80th percentile charges by CPT procedure code.* For each CPT procedure code for which outpatient facility charges apply, the 1998 practice expense RVUs (these RVU's can be found in the *1998 St. Anthony's Complete RBRVS,* Relative Value Studies, Inc., St. Anthony Publishing, 11410 Isaac Newton Square, Reston, VA 20190) are used as the outpatient facility RVUs. For each CPT procedure code, the outpatient facility RVU is multiplied by the charge amount for each incremental RVU as set forth in paragraph (d)(3) of this section. The resulting charge is adjusted by a fixed charge amount as also set forth in paragraph (d)(3) of this section to obtain the nationwide 80th percentile charge.

(3) *Charge factor.* Using the 1995 MedStat claims database of nationwide commercial insurance, the median billed facility charge is calculated for each applicable CPT procedure code. All outpatient facility CPT procedure codes are then separated into one of

the 37 outpatient facility CPT procedure code groups as set forth in paragraph (d)(3)(i) of this section. Then, for each CPT procedure code in each such group, the median charge is adjusted to the 80th percentile as set forth in paragraph (d)(3)(ii) of this section. The resulting 80th percentile charge for each CPT procedure code is trended forward to the effective time period for the charges as set forth in paragraph (d)(3)(iii) of this section. Using the resulting charges and the RVUs, the mathematical approximation methodology of least squares is applied to the data for each CPT procedure code group to derive two charge factors. The first factor represents the charge amount for each incremental RVU in the CPT procedure code group and the second factor represents a fixed charge amount adjustment for the CPT procedure code group.

(i) *Outpatient facility CPT procedure code groups.*

(A) Surgery—Integumentery System—Skin, Subcutaneous & Accessory Structures/Nails;

(B) Surgery—Integumentery System—Repair—Simple, Intermediate, Complex, Adjacent Tissue Transfer or Rearrangement;

(C) Surgery—Integumentery System—Not Otherwise Classified;

(D) Surgery—Musculoskeletal System—Not Otherwise Classified;

(E) Surgery—Musculoskeletal System—Limbs—Incisions/Excisions/Insertion/Removal;

(F) Surgery—Musculoskeletal System—Limbs—Shoulders/Humerus & Elbow/Pelvis & Hip Joint/Femur & Knee Joint—Other than Incisions/Excisions/ Insertion/Removal;

(G) Surgery—Musculoskeletal System—Limbs—Forearm & Wrist—Other than Incisions/Excisions/Insertion/Removal;

(H) Surgery—Musculoskeletal System—Limbs—Tibia/Fibula & Ankle Joint—Other than Incisions/Excisions/ Insertion/Removal;

(I) Surgery—Musculoskeletal System—Limbs—Hand & Fingers/Foot & Toes—Other than Incisions/Excisions/ Insertion/Removal;

(J) Surgery—Musculoskeletal System Arthroscopy;

(K) Surgery—Respiratory System;

(L) Surgery—Cardiovascular System;

(M) Surgery—Hemic & Lymphatic Systems;

(N) Surgery—Digestive System—Not Otherwise Classified;

(O) Surgery—Digestive System—Endoscopy;

(P) Surgery—Urinary System;

(Q) Surgery—Male Genital System;

(R) Surgery—Laparoscopy/Hysteroscopy;

(S) Surgery—Maternity Care & Delivery;

(T) Surgery—Endocrine System;

(U) Surgery—Eye/Ocular Adnexa;

(V) Surgery—Auditory System;

(W) Radiology—Diagnostic—Head & Neck/Chest/Spine & Pelvis;

(X) Radiology—Diagnostic—Extremities/Abdomen/Gastrointestinal Tract/Urinary Tract/Gynecological & Obstetrical/Heart;

(Y) Radiology—Diagnostic—Aorta & Arteries/Veins & Lymphatics;

(Z) Radiology—Diagnostic Ultrasound;

(AA) Radiology—Radiation Oncology/Nuclear Medicine/Therapeutic;

(BB) Radiology—Diagnostic—CAT Scans;

(CC) Radiology—Diagnostic—Magnetic Resonance Imaging (MRI);

(DD) Medicine—Global—Not Otherwise Classified;

(EE) Medicine—Global—Dialysis;

(FF) Medicine—Technical Component—Gastroenterology;

(GG) Medicine—Technical Component—Cardiovascular;

(HH) Medicine—Technical Component—Pulmonary;

(II) Medicine—Technical Component—Neurology & Neuromuscular Procedures;

(JJ) Medicine—Observation Care; and

(KK) Medicine—Emergency.

(ii) *80th percentile.* For each of the 37 outpatient facility CPT procedure code groups set forth in paragraph (d)(3)(i) of this section, the median charge is increased by the ratio of the 80th percentile charge to median charge (the data for CPT procedure code groups listed at paragraphs (d)(3)(i)(DD), (EE), (JJ), and (KK) of this section are obtained from the MedStat database of nationwide charges; the data for the other groups are obtained from the Outpatient Facility UCR module of the

Comprehensive Healthcare Payment System from MediCode, Inc., a 1997 release from a nationwide database of outpatient facility charges) (MediCode, Inc., 5225 Wiley Post Way, Suite 500, Salt Lake, UT 84116). To mitigate the impact of the variation in the intensity of services by CPT procedure code, the percent increase from the median to the 80th percentile in outpatient charges is compared to the percent increase from the median to the 80th percentile in inpatient semi-private room and board charges. Any percent increase in outpatient charges in excess of the inpatient semi-private room and board percent increase is multiplied by a factor of 0.50. The 80th percentile outpatient facility charge is reduced accordingly.

(iii) *Trending forward.* The charges for each CPT procedure code, representing calculations for calendar year 1995, are trended forward for the period August 1998 through September 1999, and for each 12-month calendar year period thereafter, beginning January 1, 2000, based on changes to the Outpatient Hospital component of the CPI–U. Actual CPI–U changes are used through the latest available month. The three-month average annual trend rate as of the latest available month is held constant to the midpoint of the effective charge period. The projected total CPI–U change from 1995 to this midpoint of the effective charge period is then applied to the 1995 80th percentile charges.

(4) *Geographic area adjustment factors.* For each VA outpatient facility location, a single geographic area adjustment factor is calculated as the arithmetic average of the outpatient geographic area adjustment factor (this factor constitutes the ratio of the level of charges for each geographic area to the nationwide level of charges) published in the Milliman & Robertson, Inc. Health Cost Guidelines (Milliman & Robertson, Inc., 1301 5th Ave., Suite 3800, Seattle, WA 98101–2605), and a geographic area adjustment factor developed from the MediCode data. The MediCode-based geographic area adjustment factors are calculated as the ratio of the CPT-weighted average charge level for each VA outpatient facility location to the nationwide CPT-weighted average charge level.

(5) *Multiple surgical procedures.* When multiple surgical procedures are performed during the same outpatient encounter by a provider or provider team as indicated by multiple surgical CPT procedure codes, then the CPT procedure code with the highest facility charge will be billed at 100% of the charges established under this section; the CPT procedure code with the second highest facility charge will be billed at 25% of the charges established under this section; the CPT procedure code with the third highest facility charge will be billed at 15% of the charges established under this section; and no outpatient facility charges will be billed for any additional surgical procedures.

(e) *Physician charges.* When VA provides or furnishes physician services within the scope of care referred to in paragraph (a)(1) of this section, physician charges billed for such services will be determined in accordance with the provisions of this paragraph. Physician charges consist of charges for professional services that vary by VA facility and by CPT procedure code. These charges are calculated as follows:

(1) *Formula.* For each CPT procedure code except those for anesthesia and pathology, multiply the total facility-adjusted RVU as set forth in paragraph (e)(2) of this section by the applicable facility-adjusted conversion factor (facility-adjusted conversion factors are expressed in monetary amounts) set forth in paragraph (e)(3) of this section to obtain the physician charge for each CPT procedure code at a particular VA facility. For each anesthesia and pathology CPT procedure code, multiply the nationwide physician charge as set forth in paragraph (e)(4) of this section by the geographic area adjustment factor as set forth in paragraph (e)(3)(iii) of this section to obtain the physician charge for each anesthesia and pathology CPT procedure code at a particular VA facility.

(2)(i) *Total facility-adjusted RVUs for physician services other than anesthesia, pathology, and specified CPT procedure codes.* The work expense and practice expense components of the RVUs for

CPT procedure codes (other than anesthesia, pathology, and those CPT procedure codes set forth at paragraphs (e)(2)(ii) and (e)(2)(iii) of this section) are compiled (information concerning the RVUs and their components can be obtained from Veterans Health Administration, Office of Finance, Department of Veterans Affairs, 810 Vermont Ave., NW., Washington, DC 20420). For radiology CPT procedure codes, these compilations do not include separately identified technical component RVUs. For CPT procedure codes that generate an outpatient facility charge, the facility practice expense RVU is substituted for the non-facility practice expense RVU (information concerning facility practice expense RVUs can be obtained from Veterans Health Administration, Office of Finance, Department of Veterans Affairs, 810 Vermont Ave., NW., Washington, DC 20420). For Medicine and Surgery CPT procedure codes with separate professional and technical components that also generate an outpatient facility charge, only the professional component is compiled. The sum of the facility-adjusted work expense RVU as set forth in paragraph (e)(2)(i)(A) of this section and the facility-adjusted practice expense RVU as set forth in paragraph (e)(2)(i)(B) of this section equals the total facility-adjusted RVUs.

(A) *Facility-adjusted work expense RVUs.* For each CPT procedure code for each geographic area, the 1998 work expense RVU is multiplied by the 1998 Medicare work adjuster (0.917) and the results are further multiplied by the work expense 1998 Medicare Geographic Practice Cost Index. The result constitutes the facility-adjusted work expense RVU.

(B) *Facility-adjusted practice expense RVUs.* For each CPT procedure code for each geographic area, the 1998 practice expense RVU is multiplied by the practice expense 1998 Medicare Geographic Practice Cost Index. The result constitutes the facility-adjusted practice expense RVU.

(ii) *RVUs for specified CPT procedure codes.* For the following CPT procedure codes, obtain the nationwide 80th percentile billed charges from the nationwide commercial insurance data base compiled by the Health Insurance Association of America (Health Insurance Association of America, 555 13th Street, NW, suite 600E, Washington, DC 20004): 20930, 20936, 22841, 48160, 48550, 54440, 79900, 80050, 80055, 80103, 80500, 80502, 85060, 85095, 85097, 85102, 86077, 86078, 86079, 86485, 86490, 86510, 86580, 86585, 86586, 86850, 86860, 86870, 86890, 86891, 86901, 86910, 86911, 86915, 86920, 86921, 86922, 86927, 86930, 86931, 86932, 86945, 86950, 86965, 86970, 86971, 86972, 86975, 86977, 86978, 86985, 88000, 88005, 88012, 88014, 88016, 88036, 88037, 88104, 88106, 88107, 88108, 88125, 88160, 88161, 88162, 88170, 88171, 88172, 88173, 88180, 88182, 88300, 88302, 88304, 88305, 88307, 88309, 88311, 88312, 88313, 88314, 88318, 88319, 88321, 88323, 88325, 88329, 88331, 88332, 88342, 88346, 88347, 88348, 88349, 88355, 88356, 88358, 88362, 88365, 89100, 89105, 89130, 89132, 89135, 89140, 89141, 89250, 89350, 89360, 92390, 92391, 94642, 94772, 99024, 99071, 99078, 99080, 99082, 99100, 99116, 99135, 99140, 99420, 99450, 99455, 99456. For the following CPT procedure codes, obtain the nationwide 80th percentile billed charges from the Medicare Standard Analytical File 5% Sample: 99070, M0076, M0300. Then divide the nationwide 80th percentile billed charges by the untrended nationwide conversion factor for the corresponding physician CPT procedure code group as set forth in paragraphs (e)(3) and (e)(3)(i). The resulting nationwide total RVUs are multiplied by the geographic adjustment factors as set forth in paragraph (e)(2)(iv) of this section to obtain the facility-specific total RVUs.

(iii) *RVUs for specified CPT procedure codes.* For the following list of CPT procedure codes, the nationwide total RVU is calculated by multiplying the 1998 Medicare work adjuster (0.917) by the work expense RVU and adding the practice expense RVU (the work expense RVU and the practice expense RVU for these CPT procedure codes can be found in the *1998 St. Anthony's Complete RBRVS,* Relative Value Studies, Inc., St. Anthony Publishing, 11410 Isaac Newton Square, Reston, VA 20190): 15824, 15825, 15826, 15828, 15829, 15876, 15877, 15878, 15879, 17380, 21088, 24940, 26587, 32850, 33930, 33940, 36415, 36468, 36469, 41820, 41821, 41850, 41870, 47133, 48554, 50300, 58974, 65760, 65765, 65767, 65771, 69090, 69710, 75556, 76092,

76140, 76350, 78608, 78609, 90700, 90701, 90702, 90703, 90704, 90705, 90706, 90707, 90708, 90709, 90710, 90711, 90712, 90713, 90714, 90716, 90717, 90718, 90179, 90720, 90721, 90724, 90725, 90726, 90727, 90728, 90730, 90732, 90733, 90735, 90737, 90741, 90742, 90744, 90745, 90746, 90747, 90882, 90889, 90989, 90993, 92531, 92532, 92533, 92534, 92551, 92559, 92560, 92590, 92591, 92592, 92593, 92594, 92595, 92992, 92993, 93760, 93762, 93784, 93786, 93788, 93790, 95120, 95125, 95130, 95131, 95132, 95133, 95134, 96110, 96545, 97545, 97546, 99000, 99001, 99002, 99025, 99050, 99052, 99054, 99056, 99058, 99075, 99090, 99190, 99191, 99192, 99288, 99358, 99359, 99360, 99361, 99362, 99371, 99372, 99373. The resulting nationwide total RVUs are multiplied by the geographic adjustment factors as set forth in paragraph (e)(2)(iv) of this section to obtain the facility-specific total RVUs.

(iv) *RVU geographic area adjustment factors for specified CPT procedure codes.* The geographic area adjustment factor for each facility location consists of the weighted average of the 1998 work expense and practice expense Medicare Geographic Practice Cost Indices for each facility location using charge data for representative CPT procedure codes statistically selected and weighted for work expense and practice expense.

(3) *Facility-adjusted 80th percentile conversion factors.* CPT procedure codes are separated into the following 24 physician CPT procedure code groups: allergy immunotherapy, allergy testing, anesthesia, cardiovascular, chiropractor, consults, emergency room visits and observation care, hearing/speech exams, immunizations, inpatient visits, maternity/cesarean deliveries, maternity/non-deliveries, maternity/normal deliveries, miscellaneous medical, office/home urgent care visits, outpatient psychiatry/alcohol and drug abuse, pathology, physical exams, physical medicine, radiology, surgery, therapeutic injections, vision exams, and well baby exams. For each of the 24 physician CPT procedure code groups, representative CPT procedure codes were statistically selected and weighted so as to give a weighted average RVU comparable to the weighted average RVU of the entire physician CPT procedure code group (the selected CPT procedure codes are set forth in the 1998 Milliman & Robertson, Inc., Health Cost Guidelines fee survey) (Milliman & Robertson, Inc., 1301 5th Ave., suite 3800, Seattle, WA 98101–2605). The 80th percentile charge for each selected CPT procedure code is obtained (this is contained in the nationwide commercial insurance data base compiled by the Health Insurance Association of America, 555 13th Street NW., Suite 600E, Washington, DC 20004 (medical data for 5/1/96–4/30/97, including radiology and pathology; surgical data for 3/1/96–2/28/97; anesthesia data for 3/1/96–2/28/97)). A nationwide conversion factor (a monetary amount) is calculated for each physician CPT procedure code group as set forth in paragraph (e)(3)(i) of this section. The nationwide conversion factors for each of the 24 physician CPT procedure code groups are trended forward as set forth in paragraph (e)(3)(ii) of this section. The resulting amounts for each of the 24 groups are multiplied by geographic area adjustment factors as set forth in paragraph (e)(3)(iii) of this section, resulting in facility-adjusted 80th percentile conversion factors for each VA facility geographic area for the 24 physician CPT procedure code groups for the effective charge period.

(i) *Nationwide conversion factors.* Using the nationwide 80th percentile charges for the selected CPT procedure codes from paragraph (e)(3) of this section, a nationwide conversion factor is calculated for each of the 24 physician CPT procedure code groups by dividing the weighted average charge by the weighted average RVU. To correspond with the charge data, for medicine and surgery CPT procedure codes, the total RVUs are used even when separate professional and technical components are specified.

(ii) *Trending forward.* The nationwide conversion factor for each of the 24 physician CPT procedure code groups, representing charges for time periods detailed in paragraph (e)(3) of this section, are trended forward for the period August 1998 through September 1999, and for each 12-month calendar year period thereafter, beginning January 1, 2000, based on changes to the Physician component of the CPI–U. Actual CPI–U changes are used through the latest

available month. The three-month average annual trend rate as of the latest available month is held constant to the midpoint of the effective charge period. The projected total CPI–U change from the midpoint of the source data collection period to the midpoint of the effective charge period is then applied to the 24 conversion factors.

(iii) *Geographic area adjustment factors.* Using the 80th percentile charges for the selected CPT procedure codes from paragraph (e)(3) of this section for each VA facility geographic area, a geographic area-specific conversion factor is calculated for each of the 24 physician CPT procedure code groups by dividing the weighted average charge by the weighted average facility-adjusted RVU. The resulting geographic area conversion factor for each facility geographic area for each physician CPT procedure code group is divided by the corresponding nationwide conversion factor as set forth in paragraph (e)(3)(i). The resulting ratios are the geographic area adjustment factors for each of the 24 physician CPT procedure code groups for each facility geographic area.

(4) *Nationwide 80th percentile charges for anesthesia and pathology CPT procedure codes.* The nationwide charges are calculated by multiplying the RVUs as set forth in paragraph (e)(4)(i) of this section for anesthesia CPT procedure codes and as set forth in paragraph (e)(4)(ii) of this section for pathology CPT procedure codes by the appropriate nationwide trended 80th percentile conversion factors as set forth in paragraph (e)(3) of this section.

(i) *RVUs for anesthesia.* The 1998 base unit value for each anesthesia CPT procedure code is compiled (the base unit values can be found in the *1998 St. Anthony's Complete RBRVS,* Relative Value Studies, Inc., St. Anthony Publishing, 11410 Isaac Newton Square, Reston, VA 20190). The average time unit value for each anesthesia CPT procedure code is compiled from a Health Care Financing Administration study concerning average time unit values for anesthesia CPT procedure codes (these values can be obtained from Veterans Health Administration, Office of Finance, Department of Veterans Affairs, 810 Vermont Ave., NW., Washington, DC 20420). For each anesthesia CPT procedure code introduced since the Health Care Financing Administration study, the time unit value is calculated as the average time unit value for all other anesthesia CPT procedure codes with the same base unit value. The sum of the anesthesia base unit value and the anesthesia time unit value equals the total anesthesia RVUs.

(ii) *RVUs for pathology.* For each pathology CPT procedure code, the 1998 Medicare payment amount is used as the RVU for the corresponding CPT procedure code (the payment amounts can be found on the Health Care Financing Administration public use files Internet site at *http://www.hcfa.gov/stats/pufiles.htm* under the heading ''Payment Rates/ Non-Institutional Providers'' and the title ''Clinical Diagnostic Laboratory Fee Schedule.''

(f) *Other provider charges.* When the following providers provide or furnish VA care within the scope of care referred to in paragraph (a)(1) of this section, charges for that care covered by a CPT procedure code will be determined based on the following indicated percentages of the amount that would be charged if the care had been provided by a physician under paragraph (e) of this section:

(1) Nurse practitioner: 85%.

(2) Clinical nurse specialist: 85%.

(3) Physician Assistant: 85%.

(4) Certified registered nurse anesthetist: 50% when physician supervised; 100% when not physician supervised.

(5) Clinical psychologist: 80%.

(6) Clinical social worker: 75%.

(7) Podiatrist: 100%.

(8) Chiropractor: 100%.

(9) Dietitian: 75%.

(10) Clinical pharmacist: 80%.

(11) Optometrist: 100%.

(g) *Outpatient dental care and prescription drugs not administered during treatment.* Notwithstanding other provisions of this section, when VA provides or furnishes outpatient dental care or prescription drugs not administered during treatment, within the scope of care referred to in paragraph (a)(1) of this section, charges billed separately for such care will be based on VA costs in

accordance with the methodology set forth in §17.102 of this part.

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900–0606.)

(Authority: 38 U.S.C. 101, 501, 1701, 1705, 1710, 1721, 1722, 1729)

[64 FR 22678, Apr. 27, 1999]

### §17.102 Charges for care or services.

Except as provided in §17.101, charges at the indicated rates shall be made for Department of Veterans Affairs hospital care or medical services (including, but not limited to, dental services, supplies, medicines, orthopedic and prosthetic appliances, and domiciliary or nursing home care) as follows:

(a) *Furnished in error or on tentative eligibility.* Charges at rates prescribed by the Under Secretary for Health shall be made for inpatient or outpatient care or services (including domiciliary care) authorized for any person on the basis of eligibility as a veteran or a tentative eligibility determination under §17.34 but he or she was subsequently found to have been ineligible for such care or services as a veteran because the military service or any other eligibility requirement was not met, or

(b) *Furnished in a medical emergency.* Charges at rates prescribed by the Under Secretary for Health shall be made for any inpatient or outpatient care or services rendered any person in a medical emergency who was not eligible for such care or services as a veteran, if:

(1) The care or services were rendered as a humanitarian service, under §17.43(c)(1) or §17.95 to a person neither claiming eligibility as a veteran nor for whom the establishment of eligibility as a veteran was expected, or

(2) The person for whom care or services were rendered was a Department of Veterans Affairs employee or a member of a Department of Veterans Affairs employee's family; or

(c) *Furnished beneficiaries of the Department of Defense or other Federal agencies.* Except as provided for in paragraph (f) of this section and the second sentence of this paragraph, charges at rates prescribed by the Office of Management and Budget shall be made for any inpatient or outpatient care or services authorized for a member of the Armed Forces on active duty or for any beneficiary or designee of any other Federal agency. Charges for services provided a member or former member of a uniformed service who is entitled to retired or retainer pay, or equivalent pay, will be at rates prescribed by the Secretary (E.O. 11609, dated July 22, 1971, 36 FR 13747), or

(d) *Furnished pensioners of allied nations.* Charges at rates prescribed by the Under Secretary for Health shall be made for any inpatient or outpatient care or services rendered a pensioner of a nation allied with the United States in World War I and World War II; or

(e) *Furnished under sharing agreements.* Charges at rates agreed upon in an agreement for sharing specialized medical resources shall be made for all medical care or services, either on an inpatient or outpatient basis, rendered to a person designated by the other party to the agreement as a patient to be benefited under the agreement; or

(f) *Furnished military retirees with chronic disability.* Charges for subsistence at rates prescribed by the Under Secretary for Health shall be made for the period during which hospital care is rendered when such care is rendered to a member or former member of the Armed Forces required to pay the subsistence rate under §17.47 (b)(2) and (c)(2).

(g) *Furnished for research purposes.* Charges will not be made for medical services, including transportation, furnished as part of an approved Department of Veterans Affairs research project, except that if the services are furnished to a person who is not eligible for the services as a veteran, the medical care appropriation shall be reimbursed from the research appropriation at the same rates used for billings under paragraph (b) of this section.

(h) *Computation of charges.* The method for computing the charges under paragraphs (a), (b), (d), (f), and (g) and the last sentence of paragraph (c) of this section is based on the Cost Distribution Report, which sets forth the actual basic costs and per diem rates

by type of inpatient care and outpatient visit. Factors for depreciation of buildings and equipment and Central Office overhead are added, based on accounting manual instructions. Additional factors are added for interest on capital investment and for standard fringe benefit costs covering government employee retirement and disability costs. The current year billing rates are projected on prior year actual rates by applying the budgeted percentage increase. In addition, based on the detail available in the Cost Distribution Report, VA intends to, on each bill break down the all-inclusive rate into its three principal components; namely, physician cost, ancillary services cost, and nursing, room and board cost. The rates generated by the foregoing methodology are the same rates prescribed by the Office of Management and Budget and published in the FEDERAL REGISTER for use under the Federal Medical Care Recovery Act, 42 U.S.C. sections 2651–2653.

(Authority: 38 U.S.C. 1729; sec. 19013, Pub. L. 99–272)

[32 FR 11382, Aug. 5, 1967, as amended at 34 FR 7807, May 16, 1969; 35 FR 11470, July 17, 1970; 36 FR 18794, Sept. 22, 1971; 47 FR 50861, Nov. 10, 1982; 47 FR 58249, Dec. 1982; 52 FR 3010, Jan. 30, 1987. Redesignated and amended at 61 FR 21965, 21967, May 13, 1996; 62 FR 17072, Apr. 9, 1997. Redesignated and amended at 64 FR 22678, 22683, Apr. 27, 1999]

### § 17.103 Referrals of compromise settlement offers.

Any offer to compromise or settle any charges or claim for $20,000 or less asserted by the Department of Veterans Affairs in connection with the medical program shall be referred as follows:

(a) *To Chiefs of Fiscal activities.* If the debt represents charges made under § 17.101(a), the compromise offer shall be referred to the Chief of the Fiscal activity of the facility for application of the collection standards in § 1.900 *et seq.* of this chapter, provided:

(1) The debt does not exceed $1,000, and

(2) There has been a previous denial of waiver of the debt by a field station Committee on Waivers and Compromises.

(b) *To Regional Counsel.* If the debt in any amount represents charges for medical services for which there is or may be a claim against a third party tort-feasor or under workers' compensation laws or Pub. L. 87–693; 76 Stat. 593 (see § 1.903 of this chapter) or involves a claim contemplated by § 1.902 of this chapter over which the Department of Veterans Affairs lacks jurisdiction, the compromise offer (or request for waiver or proposal to terminate or suspend collection action) shall be promptly referred to the field station Regional Counsel having jurisdiction in the area in which the claim arose, or

(c) *To Committee on Waivers and Compromises.* If one of the following situations contemplated in paragraph (c)(1) through (3) of this section applies

(1) If the debt represents charges made under § 17.101(a), but is not of a type contemplated in paragraph (a) of this section, or

(2) If the debt represents charges for medical services made under § 17.101(b), or

(3) A claim arising in connection with any transaction of the Veterans Health Administration for which the instructions in paragraph (a) or (b) of this section or in § 17.105(c) are not applicable, then, the compromise offer should be referred for disposition under § 1.900 *et seq.* of this chapter to the field station Committee on Waivers and Compromises which shall take final action.

[39 FR 26403, July 19, 1974, as amended at 47 FR 58250, Dec. 30, 1982. Redesignated and amended at 61 FR 21966, 21967, May 13, 1996; 62 FR 17072, Apr. 9, 1997]

### § 17.104 Terminations and suspensions.

Any proposal to suspend or terminate collection action on any charges or claim for $20,000 or less asserted by the Department of Veterans Affairs in connection with the medical program shall be referred as follows:

(a) *Of charges for medical services.* If the debt represents charges made under § 17.101 (a) or (b) questions concerning suspension or termination of collection action shall be referred to the Chief of the Fiscal activity of the station for

application of the collection standards in § 1.900 *et seq.* of this chapter, or

(b) *Of other debts.* If the debt is of a type other than those contemplated in paragraph (a) of this section, questions concerning suspension or termination of collection action shall be referred in accordance with the same referral procedures for compromise offers (except the Fiscal activity shall make final determinations in terminations or suspensions involving claims of $150 or less pursuant to the provisions of § 1.900 *et seq.* of this chapter.)

[34 FR 7807, May 16, 1969, as amended at 39 FR 26403, July 19, 1974. Redesignated and amended at 61 FR 21966, 21967, May 13, 1996]

### § 17.105 Waivers.

Applications or requests for waiver of debts or claims asserted by the Department of Veterans Affairs in connection with the medical program generally will be denied by the facility Fiscal activity on the basis there is no legal authority to waive debts, unless the question of waiver should be referred as follows:

(a) *Of charges for medical services.* If the debt represents charges made under § 17.101(a), the application or request for waiver should be referred for disposition under § 1.900 *et seq.* of this chapter to the field facility Committee on Waivers and Compromises which shall take final action, or

(b) *Of claims against third persons and other claims.* If the debt is of a type contemplated in § 17.103(b), the waiver question should be referred in accordance with the same referral procedures for compromise offers in such categories of claims, or

(c) *Other debts.* If the debt represents any claim or charges other than those contemplated in paragraphs (a) and (b) of this section, and is a debt for which waiver has been specifically provided for by law or under the terms of a contract, initial action shall be taken at the station level for referral of the request for waiver through channels for action by the appropriate designated official. If, however, the question of waiver may also involve a concurrent opportunity to negotiate a compromise settlement, the application shall be referred to the Committee on Waivers and Compromises.

[39 FR 26403, July 19, 1974. Redesignated and amended at 61 FR 21966, 21967, May 13, 1996]

## DISCIPLINARY CONTROL OF BENEFICIARIES RECEIVING HOSPITAL, DOMICILIARY OR NURSING HOME CARE

### § 17.106 Authority for disciplinary action.

The good conduct of beneficiaries receiving hospitalization for observation and examination or for treatment, or receiving domiciliary or nursing home care in facilities under direct and exclusive jurisdiction of the Department of Veterans Affairs, will be maintained by corrective and disciplinary procedure formulated by the Department of Veterans Affairs. Such corrective and disciplinary measures, to be selectively applied in keeping with the comparative gravity of the particular offense, will consist, in respect to hospital patients, of such penalties as the withholding for a determined period of pass privileges, exclusion from entertainments, or disciplinary discharge; and, in respect to domiciled members, such penalties as confinement to sections or grounds, deprivation of privileges, enforced furlough, or disciplinary discharge. Also, for any violation of the Department of Veterans Affairs rules set forth in § 1.218, or other Federal laws on Department of Veterans Affairs property, a beneficiary is subject to the penalty prescribed for the offense.

[38 FR 24366, Sept. 7, 1973. Redesignated at 61 FR 21966, May 13, 1996]

## CEREMONIES

### § 17.110 [Reserved]

### § 17.111 Services or ceremonies on Department of Veterans Affairs hospital or center reservations.

(a) Services or ceremonies on Department of Veterans Affairs hospital or center reservations are subject to the following limitations:

(1) All activities must be conducted with proper decorum, and not interfere with the care and treatment of patients. Organizations must provide assurance that their members will obey

all rules in effect at the hospital or center involved, and act in a dignified and proper manner;

(2) Partisan activities are inappropriate and all activities must be nonpartisan in nature. An activity will be considered partisan and therefore inappropriate if it includes commentary in support of, or in opposition to, or attempts to influence, any current policy of the Government of the United States or any State of the United States. If the activity is closely related to partisan activities being conducted outside the hospital or center reservations, it will be considered partisan and therefore inappropriate.

(b) Requests for permission to hold services or ceremonies will be addressed to the Secretary, or the Director of the Department of Veterans Affairs hospital or center involved. Such applications will describe the proposed activity in sufficient detail to enable a determination as to whether it meets the standards set forth in paragraph (a) of this section. If permission is granted, the Director of the hospital or center involved will assign an appropriate time, and render assistance where appropriate. No organization will be given exclusive permission to use the hospital or center reservation on any particular occasion. Where several requests are received for separate activities, the Director will schedule each so as to avoid overlapping or interference, or require appropriate modifications in the scope or timing of the activity.

[35 FR 2389, Feb. 3, 1970. Redesignated at 61 FR 21966, May 13, 1996]

REIMBURSEMENT FOR LOSS BY NATURAL DISASTER OF PERSONAL EFFECTS OF HOSPITALIZED OR NURSING HOME PATIENTS

### § 17.112 Conditions of custody.

When the personal effects of a patient who has been or is hospitalized or receiving nursing home care in a Department of Veterans Affairs hospital or center were or are duly delivered to a designated location for custody and loss of such personal effects has occurred or occurs by fire, earthquake, or other natural disaster, either during such storage or during laundering, reimbursement will be made as provided in §§ 17.113 and 17.114.

[39 FR 1843, Jan. 15, 1974. Redesignated and amended at 61 FR 21966, 21967, May 13, 1996]

### § 17.113 Submittal of claim for reimbursement.

The claim for reimbursement for personal effects damaged or destroyed will be submitted by the patient to the Director. The patient will separately list and evaluate each article with a notation as to its condition at the time of the fire, earthquake, or other natural disaster i.e. whether new, worn, etc. The date of the fire, earthquake, or other natural disaster will be stated. It will be certified by a responsible official that each article listed was stored in a designated location at the time of loss by fire, earthquake, or other natural disaster or was in process of laundering. The patient will further state whether the loss of each article was complete or partial, permitting of some further use of the article. The responsible official will certify that the amount of reimbursement claimed on each article of personal effects is not in excess of the fair value thereof at time of loss. The certification will be prepared in triplicate, signed by the responsible officer who made it, and countersigned by the Director of the medical center. After the above papers have been secured, voucher will be prepared, signed, and certified, and forwarded to the Fiscal Officer for approval, payment to be made in accordance with fiscal procedure. The original list of property and certificate are to be attached to voucher.

[39 FR 1843, Jan. 15, 1974, as amended at 49 FR 5616, Feb. 14, 1984. Redesignated at 61 FR 21966, May 13, 1996]

### § 17.114 Claims in cases of incompetent patients.

Where the patient is insane and incompetent, the patient will not be required to make claim for reimbursement for personal effects lost by fire, earthquake, or other natural disaster as required under the provisions of § 17.113. The responsible official will make claim for the patient, adding the certification in all details as provided for in § 17.113. After countersignature of

this certification by the Director, payment will be made as provided in §17.113, and the amount thereby disbursed will be turned over to the Director for custody.

[39 FR 1843, Jan. 15, 1974, as amended at 49 FR 5616, Feb. 14, 1984. Redesignated and amended at 61 FR 21966, 21967, May 13, 1996]

REIMBURSEMENT TO EMPLOYEES FOR THE COST OF REPAIRING OR REPLACING CERTAIN PERSONAL PROPERTY DAMAGED OR DESTROYED BY PATIENTS OR MEMBERS

### §17.115 Adjudication of claims.

*Claims comprehended.* Claims for reimbursing Department of Veterans Affairs employees for cost of repairing or replacing their personal property damaged or destroyed by patients or members while such employees are engaged in the performance of their official duties will be adjudicated by the Director of the medical center concerned. Such claims will be considered under the following conditions, both of which must have existed and, if either one is lacking, reimbursement or payment for the cost or repair of the damaged article will not be authorized:

(a) The claim must be for an item of personal property normally used by the employee in his or her day to day employment, e.g., eyeglasses, hearing aids, clothing, etc., and,

(b) Such personal property was damaged or destroyed by a patient or domiciliary member while the employee was engaged in the performance of official duties.

Reimbursement or payment as provided in this paragraph will be made in a fair and reasonable amount, taking into consideration the condition and reasonable value of the article at the time it was damaged or destroyed.

[28 FR 5083, May 22, 1963, as amended at 39 FR 1843, Jan. 15, 1974; 49 FR 5616, Feb. 14, 1984. Redesignated and amended at 61 FR 21965, May 13, 1996]

PAYMENT AND REIMBURSEMENT OF THE EXPENSES OF MEDICAL SERVICES NOT PREVIOUSLY AUTHORIZED

### §17.120 Payment or reimbursement of the expenses of hospital care and other medical services not previously authorized.

To the extent allowable, payment or reimbursement of the expenses of care, not previously authorized, in a private or public (or Federal) hospital not operated by the Department of Veterans Affairs, or of any medical services not previously authorized including transportation (except prosthetic appliances, similar devices, and repairs) may be paid on the basis of a claim timely filed, under the following circumstances:

(a) *For veterans with service connected disabilities.* Care or services not previously authorized were rendered to a veteran in need of such care or services:

(1) For an adjudicated service-connected disability;

(2) For nonservice-connected disabilities associated with and held to be aggravating an adjudicated service-connected disability;

(3) For *any disability* of a veteran who has a total disability permanent in nature resulting from a service-connected disability (does not apply outside of the States, Territories, and possessions of the United State, the District of Columbia, and the Commonwealth of Puerto Rico);

(4) For any illness, injury or dental condition in the case of a veteran who is participating in a rehabilitation program under 38 U.S.C. ch. 31 and who is medically determined to be in need of hospital care or medical services for any of the reasons enumerated in §17.48(j); and

(Authority: 38 U.S.C. 1724, 1728)

(b) *In a medical emergency.* Care and services not previously authorized were rendered in a medical emergency of such nature that delay would have been hazardous to life or health, and

(c) *When Federal facilities are unavailable.* VA or other Federal facilities were not feasibly available, and an attempt to use them beforehand or obtain prior VA authorization for the services required would not have been reasonable, sound, wise, or practicable, or treatment had been or would have been refused.

(Authority: 38 U.S.C. 1724, 1728, 7304)

[39 FR 1844, Jan. 15, 1974, as amended at 49 FR 5616, Feb. 14, 1984; 51 FR 8672, Mar. 13, 1986; 56 FR 3422, Jan. 30, 1991. Redesignated at 61 FR 21966, May 13, 1996]

### § 17.121 Limitations on payment or reimbursement of the costs of emergency hospital care and medical services not previously authorized.

Claims for payment or reimbursement of the costs of emergency hospital care or medical services not previously authorized will not be approved for any period beyond the date on which the medical emergency ended. For the purpose of payment or reimbursement of the expense of emergency hospital care or medical services not previously authorized, an emergency shall be deemed to have ended at that point when a VA physician has determined that, based on sound medical judgment, a veteran:

(a) Who received emergency hospital care could have been transferred from the non-VA facility to a VA medical center for continuation of treatment for the disability, or

(b) Who received emergency medical services, could have reported to a VA medical center for continuation of treatment for the disability.

From that point on, no additional care in a non-VA facility will be approved for payment by VA.

(Authority: 38 U.S.C. 501(c)(1))

[49 FR 15548, Apr. 19, 1984. Redesignated at 61 FR 21966, May 13, 1996]

### § 17.122 Payment or reimbursement of the expenses of repairs to prosthetic appliances and similar devices furnished without prior authorization.

The expenses of repairs to prosthetic appliances, or similar appliances, therapeutic or rehabilitative aids or devices, furnished without prior authorization, but incurred in the care of an adjudicated service-connected disability (or, in the case of a veteran who is participating in a rehabilitation program under 38 U.S.C. ch. 31 and who is determined to be in need of the repairs for any of the reasons enumerated in § 17.47(g)) may be paid or reimbursed on the basis of a timely filed claim, if

(Authority: 38 U.S.C. 1728)

(a) Obtaining the repairs locally was necessary, expedient, and not a matter of preference to using authorized sources, and

(b) The costs were reasonable, except that where it is determined the costs were excessive or unreasonable, the claim may be allowed to the extent the costs were deemed reasonable and disallowed as to the remainder. In no circumstances will any claim for repairs be allowed to the extent the costs exceed $125.

(Authority: 38 U.S.C. 1728, 7304)

[33 FR 19011, Dec. 20, 1968, as amended at 49 FR 5616, Feb. 14, 1984; 51 FR 8672, Mar. 13, 1986. Redesignated and amended at 61 FR 21966, 21967, May 13, 1996]

### § 17.123 Claimants.

A claim for payment or reimbursement of services not previously authorized may be filed by the veteran who received the services (or his/her guardian) or by the hospital, clinic, or community resource which provided the services, or by a person other than the veteran who paid for the services.

[39 FR 1844, Jan. 15, 1974, as amended at 45 FR 53807, Aug. 13, 1980. Redesignated at 61 FR 21966, May 13, 1996]

### § 17.124 Preparation of claims.

Claims for costs of services not previously authorized shall be on such forms as shall be prescribed and shall include the following:

(a) The claimant shall specify the amount claimed and furnish bills, vouchers, invoices, or receipts or other documentary evidence establishing that such amount was paid or is owed, and

(b) The claimant shall provide an explanation of the circumstances necessitating the use of community medical care, services, or supplies instead of

Department of Veterans Affairs care, services, or supplies, and

(c) The claimant shall furnish such other evidence or statements as are deemed necessary and requested for adjudication of the claim.

[33 FR 19011, Dec. 20, 1968, as amended at 39 FR 1844, Jan. 15, 1974. Redesignated at 61 FR 21966, May 13, 1996]

### § 17.125 Where to file claims.

Claims for payment or reimbursement of the expenses of services not previously authorized should be filed as follows:

(a) *For services rendered in the U.S.* Claims for the expenses of care or services rendered in the United States, including the Territories or possessions of the United States, should be filed with the Chief, Outpatient Service, or Clinic Director of the VA facility designated as a clinic or jurisdiction which serves the region in which the care or services were rendered, and

(Authority: 38 U.S.C. 7304)

(b) *For services rendered in the Philippines.* Claims for the expenses of care or services rendered in the Republic of the Philippines should be filed with the Department of Veterans Affairs Outpatient Clinic (358/00), 2201 Roxas Blvd., Pasay City, 1300, Republic of the Philippines, and

(c) *For services rendered in Canada.* Claims for the expenses of care or services rendered in Canada should be filed with the Chief, Medical Administration Service (136), Department of Veterans Affairs Medical Center, White River Junction, VT 05009, and

(d) *For services rendered in other foreign countries.* Claims for the expenses of care or services rendered in other foreign countries must be mailed to the Health Administration Center, P.O. Box 65023, Denver, CO 80206–3023.

(Authority: 38 U.S.C. 7304)

(e) *For services rendered in Puerto Rico.* Claims for the expenses of care or services rendered in the Commonwealth of Puerto Rico should be filed with the Department of Veterans Affairs Medical and Regional Office Center, San Juan, PR.

[33 FR 19011, Dec. 20, 1968, as amended at 39 FR 1844, Jan. 15, 1974; 45 FR 53807, Aug. 13, 1980; 51 FR 8673, Mar. 13, 1986. Redesignated and amended at 61 FR 21966, 21967, May 13, 1996]

### § 17.126 Timely filing.

Claims for payment or reimbursement of the expenses of medical care or services not previously authorized must be filed within the following time limits:

(a) A claim must be filed within 2 years after the date the care or services were rendered (and in the case of continuous care, payment will not be made for any part of the care rendered more than 2 years prior to filing claim), or

(b) In the case of case or services rendered prior to a VA adjudication allowing service-connection:

(1) The claim must be filed within 2 years of the date the veteran was notified by VA of the allowance of the award of service-connection.

(2) VA payment may be made for care related to the service-connected disability received only within a 2-year period prior to the date the veteran filed the original or reopened claim which resulted in the award of service-connection but never prior to the effective date of the award of service-connection within that 2-year period.

(3) VA payment will never be made for any care received beyond this 2-year period whether service connected or not.

(Authority: 38 U.S.C. 7304)

[33 FR 19012, Dec. 20, 1968, as amended at 39 FR 1844, Jan. 15, 1974; 45 FR 53807, Aug. 13, 1980; 51 FR 8673, Mar. 13, 1986. Redesignated at 61 FR 21966, May 13, 1996]

### § 17.127 Date of filing claims.

The date of filing any claim for payment or reimbursement of the expenses of medical care and services not previously authorized shall be the postmark date of a formal claim, or the date of any preceding telephone call,

telegram, or other communication constituting an informal claim.

[39 FR 1844, Jan. 15, 1974. Redesignated at 61 FR 21966, May 13, 1996]

### § 17.128 Allowable rates and fees.

When it has been determined that a veteran has received public or private hospital care or outpatient medical services, the expenses of which may be paid under § 17.120 of this part, the payment of such expenses shall be paid in accordance with §§ 17.55 and 17.56 of this part.

(Authority: Section 233, Pub. L. 99–576)

[63 FR 39515, July 23, 1998]

### § 17.129 Retroactive payments prohibited.

When a claim for payment or reimbursement of expenses of services not previously authorized has not been timely filed in accordance with the provisions of § 17.126, the expenses of any such care or services rendered prior to the date of filing the claim shall not be paid or reimbursed. In no event will a bill or claim be paid or allowed for any care or services rendered prior to the effective date of any law, or amendment to the law, under which eligibility for the medical services at Department of Veterans Affairs expense has been established.

[39 FR 1844, Jan. 15, 1974. Redesignated and amended at 61 FR 21966, 21968, May 13, 1996]

### § 17.130 Payment for treatment dependent upon preference prohibited.

No reimbursement or payment of services not previously authorized will be made when such treatment was procured through private sources in preference to available Government facilities.

[39 FR 1844, Jan. 15, 1974. Redesignated at 61 FR 21966, May 13, 1996]

### § 17.131 Payment of abandoned claims prohibited.

Any informal claim for the payment or reimbursement of medical expenses which is not followed by a formal claim, or any formal claim which is not followed by necessary supporting evidence, within 1 year from the date of the request for a formal claim or supporting evidence shall be deemed abandoned, and payment or reimbursement shall not be authorized on the basis of such abandoned claim or any future claim for the same expenses. For the purpose of this section, time limitations shall be computed from the date following the date of request for a formal claim or supporting evidence.

[33 FR 19012, Dec. 20, 1968. Redesignated at 61 FR 21966, May 13, 1996]

### § 17.132 Appeals.

When any claim for payment or reimbursement of expenses of medical care or services rendered in non-Department of Veterans Affairs facilities or from non-Department of Veterans Affairs resources has been disallowed, the claimant shall be notified of the reasons for the disallowance and of the right to initiate an appeal to the Board of Veterans Appeals by filing a Notice of Disagreement, and shall be furnished such other notices or statements as are required by part 19 of this chapter, governing appeals.

[33 FR 19012, Dec. 20, 1968. Redesignated at 61 FR 21966, May 13, 1996]

## RECONSIDERATION OF DENIED CLAIMS

### § 17.133 Procedures.

(a) *Scope.* This section sets forth reconsideration procedures regarding claims for benefits administered by the Veterans Health Administration (VHA). These procedures apply to claims for VHA benefits regarding decisions that are appealable to the Board of Veterans' Appeals (e.g., reimbursement for non-VA care not authorized in advance, reimbursement for beneficiary travel expenses, reimbursement for home improvements or structural alterations, etc.). These procedures do not apply when other regulations providing reconsideration procedures do apply (this includes CHAMPVA (38 CFR 17.270 through 17.278) and spina bifida (38 CFR 17.904) and any other regulations that contain reconsideration procedures). Also, these procedures do not apply to decisions made outside of VHA, such as decisions made by the Veterans Benefits Administration and adopted by VHA for decisionmaking. These procedures are not mandatory,

and a claimant may choose to appeal the denied claim to the Board of Veterans' Appeals pursuant to 38 U.S.C. 7105 without utilizing the provisions of this section. Submitting a request for reconsideration shall constitute a notice of disagreement for purposes of filing a timely notice of disagreement under 38 U.S.C. 7105(b).

(b) *Process.* An individual who disagrees with the initial decision denying the claim in whole or in part may obtain reconsideration under this section by submitting a reconsideration request in writing to the Director of the healthcare facility of jurisdiction within one year of the date of the initial decision. The reconsideration decision will be made by the immediate supervisor of the initial VA decision-maker. The request must state why it is concluded that the decision is in error and must include any new and relevant information not previously considered. Any request for reconsideration that does not identify the reason for the dispute will be returned to the sender without further consideration. The request for reconsideration may include a request for a meeting with the immediate supervisor of the initial VA decision-maker, the claimant, and the claimant's representative (if the claimant wishes to have a representative present). Such a meeting shall only be for the purpose of discussing the issues and shall not include formal procedures (e.g., presentation, cross-examination of witnesses, etc.). The meeting will be taped and transcribed by VA if requested by the claimant and a copy of the transcription shall be provided to the claimant. After reviewing the matter, the immediate supervisor of the initial VA decision-maker shall issue a written decision that affirms, reverses, or modifies the initial decision.

NOTE TO §17.133: The final decision of the immediate supervisor of the initial VA decision-maker will inform the claimant of further appellate rights for an appeal to the Board of Veterans' Appeals.

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900–0600)

(Authority: 38 U.S.C. 511, 38 U.S.C. 7105)

[64 FR 44660, Aug. 17, 1999]

DELEGATIONS OF AUTHORITY

### §17.140 Authority to adjudicate reimbursement claims.

The Department of Veterans Affairs medical installation having responsibility for the fee basis program in the region or territory (including the Republic of the Philippines) served by such medical installation shall adjudicate all claims for the payment or reimbursement of the expenses of services not previously authorized rendered in the region or territory.

[39 FR 1844, Jan. 15, 1974. Redesignated at 61 FR 21966, May 13, 1996]

### §17.141 Authority to adjudicate foreign reimbursement claims.

The Health Administration Center in Denver, CO, shall adjudicate claims for the payment or reimbursement of the expenses of services not previously authorized rendered in any foreign country except Canada which will be referred to the VA Medical Center in White River Junction, VT, and the Republic of the Philippines which will be referred to the VA Outpatient Clinic in Pasay City.

[39 FR 1844, Jan. 15, 1974, as amended at 45 FR 6938, Jan. 31, 1980. Redesignated and amended at 61 FR 21966, 21968, May 13, 1996]

### §17.142 Authority to approve sharing agreements, contracts for scarce medical specialist services and contracts for other medical services.

The Under Secretary for Health is delegated authority to enter into

(a) Sharing agreements authorized under the provisions of 38 U.S.C. 8153 and §17.210 and which may be negotiated pursuant to the provisions of 41 CFR 8–3.204(c);

(b) Contracts with schools and colleges of medicine, osteopathy, dentistry, podiatry, optometry, and nursing, clinics, and any other group or individual capable of furnishing such services to provide scarce medical specialist services at Department of Veterans Affairs health care facilities (including, but not limited to, services of physicians, dentists, podiatrists, optometrists, nurses, physicians' assistants, expanded function dental auxiliaries, technicians, and other medical support personnel); and

(c) When a sharing agreement or contract for scarce medical specialist services is not warranted, contracts authorized under the provisions of 38 U.S.C. 513 for medical and ancillary services. The authority under this section generally will be exercised by approval of proposed contracts or agreements negotiated at the health care facility level. Such approval, however, will not be necessary in the case of any purchase order or individual authorization for which authority has been delegated in §17.99. All such contracts and agreements will be negotiated pursuant to 41 CFR chapters 1 and 8.

(Authority: 38 U.S.C. 512, 513, 7409, 8153)

[45 FR 6938, Jan. 31, 1980. Redesignated at 61 FR 21966, May 13, 1996, as amended at 62 FR 17072, Apr. 9, 1997]

TRANSPORTATION OF CLAIMANTS AND BENEFICIARIES

### §17.143 Transportation of claimants and beneficiaries.

(a) If travel will be provided, it shall be paid in accordance with 38 U.S.C. 111 and this section.

(Authority: 38 U.S.C. 111)

(b) Transportation at Government expense shall be authorized for the following categories of VA beneficiaries, subject to the deductible established in §17.101, ''Limitations'':

(1) A veteran or other person traveling in connection with treatment for a service-connected disability (irrespective of percent of disability).

(2) A veteran with a service-connected disability rated at 30 percent or more, for treatment of any condition.

(3) A veteran receiving VA pension benefits.

(4) A veteran whose annual income, as determined under 38 U.S.C. 1503, does not exceed the maximum annual rate of pension which would be payable if the veteran were eligible for pension, or who is unable to defray the expenses of travel.

(c) Transportation at Government expense shall be authorized for the following VA beneficiaries without their being subject to the deductible established in §17.101, ''Limitations'':

(1) A veteran traveling in connection with a scheduled compensation or pension examination.

(2) A veteran or other person traveling by a specialized mode of transportation such as an ambulance, ambulette, air ambulance, wheelchair van, or other vehicle specially designed to transport disabled individuals provided:

(i) A physician determines that the special mode of travel is medically required;

(ii) The person is unable to defray the expenses of the travel; and

(iii) The travel is authorized in advance or was undertaken in connection with a medical emergency such that delay to obtain authorization would be hazardous to the person's life or health.

(d) For the purposes of this section, the term ''other person'' refers to:

(1) An attendant when it has been determined in advance that the beneficiary's physical or mental condition requires the presence of an attendant.

(2) A dependent or survivor receiving care in a VA facility under 38 U.S.C. 1713.

(3) Members of the veteran's immediate family, the veteran's legal guardian, or the individual in whose household the veteran certifies an intention to live, when the veteran is receiving services under 38 U.S.C. 1701(6)(B).

(e) A veteran or other person shall be considered unable to defray the expenses of travel if:

(1) Annual income for the year immediately preceding the application for benefits does not exceed the maximum annual rate of pension which would be payable if the person were eligible for pension; or

(2) The person is able to demonstrate that due to circumstances such as loss of employment, or incurrence of a disability, income in the year of application will not exceed the maximum annual rate of pension which would be payable if the person were eligible for pension; or

(3) The person has a service-connected disability rated at least 30 percent; or

(4) The person is traveling in connection with treatment of a service-connected disability.

(Authority: 38 U.S.C. 111)

(f) *Admission.* (1) Admission of applicants under 38 U.S.C. 1710, 38 CFR 17.46 and 17.84.

(2) Hospital admission for observation and examination.

(g) *Readmissions.* Hospital readmissions, when medically determined necessary to observe progress, modify treatment or diet, etc.

(h) *Preparatory and posthospital care.* When necessary to the provision of medical services furnished veterans under 38 U.S.C. 1712(a)(5), and 1717.

(i) *Authorized absence.* Transportation will not be furnished beneficiaries who are on authorized absence, to depart from or return to Department of Veterans Affairs health care facilities, except that if a patient in such status develops an emergent condition and the patient (or guardian, if there be one) is without funds to return such patient to a Department of Veterans Affairs health care facility, travel may be approved by the Director of the Department of Veterans Affairs facility to which the patient is to be returned.

(j) *Discharge.* (1) Subject to the limitations of this section, upon regular discharge from hospitalization for treatment, observation and examination, or from nursing home care, return transportation to the point from which the beneficiary had proceeded; or to another point if no additional expense be thereby caused the Government.

(2) A patient in a terminal condition may be discharged to his or her home or transferred to a hospital suitable and nearer that home, regardless of whether travel so required exceeds that covered in proceeding to the hospital of original admission.

(3) Transportation may be furnished to a point other than that from which a patient had proceeded to a hospital upon a showing of bona fide change of address of the patient's residence during the period of hospital care.

(4) No return transportation will be supplied a patient who receives an irregular discharge from hospital or nursing home care, unless the patient executes an affidavit of inability to defray the expense of return transportation.

(k) *Outpatient services.* (1) Outpatient physical examination, subject to limitations described in 38 U.S.C. 111(c) and 38 CFR 17.144, ''Limitations''.

(2) Outpatient treatment for service-connected conditions, including adjunct treatment thereof; for veterans under §17.93 (a)(2) and (d)(3); and for nonservice-connected disabilities of veterans who are participating in a rehabilitation program under 38 U.S.C. chapter 31 and who are medically determined to be in need of medical services for any of the reasons enumerated in 17.47(j), subject to limitations described in §17.144, ''Limitations''.

(Authority: 38 U.S.C. 111(b))

(l) *Accessories of transportation.* The accessories of transportation, meals and lodging en route, and accompaniment by an attendant or attendants, may be authorized when determined necessary for the travel.

(m) *Furnishing transportation and other expenses incident thereto.* In furnishing transportation and other expenses incident thereto, as defined, VA may (1) issue requests for transportation, meals, and lodging; or (2) reimburse the claimant, beneficiary or representative, for payment made for such purpose, upon due certification of vouchers submitted therefor.

The provisions of 38 U.S.C. 111 and 38 CFR 17.143, 17.144 and 17.145 will be complied with in all instances when transportation costs are claimed.

(Authority: 38 U.S.C. 111)

(n) *Transportation of other than Department of Veterans Affairs beneficiaries.* Transportation of beneficiaries of other Federal agencies, incident to medical services rendered upon requests of those agencies, will not be furnished by the Department of Veterans Affairs, except that facility vehicles may be used subject to reimbursement, and with the exception of beneficiaries of the Bureau of Old Age and Survivors Insurance in the Philippines on a reimbursable basis under agreement with that agency. Transportation incident to medical services rendered allied beneficiaries under agreement

will be subject to reimbursement by the governments concerned.

[21 FR 10387, Dec. 28, 1956]

EDITORIAL NOTE: For FEDERAL REGISTER citations affecting § 17.143, see the List of CFR Sections Affected in the Finding Aids section of this volume.

### § 17.144 Limitations.

(a) VA shall deduct from amounts payable to persons under § 17.100(b), an amount equal to $3 for each one-way trip to a VA facility, up to a maximum of $18 in any calendar month. Persons required to make more than six one-way visits per calendar month will receive full travel reimbursement after the $18 cap is met.

(b) The provisions of paragraph (a) of this section may be waived when imposition of the deductible would cause severe financial hardship. Loss of employment, or sudden illness or disability causing the beneficiary's income in the year of application to fall below the maximum level of VA pension, shall be deemed to constitute severe financial hardship.

(c) Transportation will not be authorized for the cost of travel by taxi or a hired car for visually impaired veterans (as a special mode), or by privately owned vehicle in any amount in excess of the cost of such travel by other forms of public transportation unless public transportation is not reasonably accessible or would be medically inadvisable.

(d) Transportation will not be authorized for the cost of travel in excess of the actual expense incurred by any person as certified by that person in writing.

(Authority: 38 U.S.C. 111)

[56 FR 52476, Oct. 21, 1991. Redesignated at 61 FR 21966, May 13, 1996]

### § 17.145 Approval of unauthorized travel of claimants and beneficiaries.

(a) Payment may be approved for travel performed under § 17.143(a) through (g) without prior authorization only in those cases where the Department of Veterans Affairs determines that there was a need for prompt medical care which was approved and:

(1) The circumstances prevented a request for prior travel authorization, or

(2) Due to Department of Veterans Affairs delay or error prior authorization for travel was not given, or

(3) There was a justifiable lack of knowledge on the part of a third party acting for the veteran that a request for prior authorization was necessary.

(b) In other cases, payment may be approved for such travel without prior authorization only upon a finding by the Secretary or designee that failure to secure prior authorization was justified.

(Authority: 38 U.S.C. 111)

[29 FR 11183, Aug. 4, 1964, as amended at 45 FR 6938, Jan. 31, 1980. Redesignated at 56 FR 52475, Oct. 21, 1991, and further redesignated at 61 FR 21966, May 13, 1996, as amended at 62 FR 17072, Apr. 9, 1997]

## PROSTHETIC, SENSORY, AND REHABILITATIVE AIDS

### § 17.149 Sensori-neural aids.

(a) Notwithstanding any other provision of this part, VA will furnish needed sensori-neural aids (i.e., eyeglasses, contact lenses, hearing aids) only to veterans otherwise receiving VA care or services and only as provided in this section.

(b) VA will furnish needed sensori-neural aids (i.e., eyeglasses, contact lenses, hearing aids) to the following veterans:

(1) Those with a compensable service-connected disability;

(2) Those who are former prisoners of war;

(3) Those in receipt of benefits under 38 U.S.C. 1151;

(4) Those in receipt of increased pension based on the need for regular aid and attendance or by reason of being permanently housebound;

(5) Those who have a visual or hearing impairment that resulted from the existence of another medical condition for which the veteran is receiving VA care, or which resulted from treatment of that medical condition;

(6) Those with a significant functional or cognitive impairment evidenced by deficiencies in activities of daily living, but not including normally occurring visual or hearing impairments; and

(7) Those visually or hearing impaired so severely that the provision of sensori-neural aids is necessary to permit active participation in their own medical treatment.

(c) VA will furnish needed hearing aids to those veterans who have service-connected hearing disabilities rated 0 percent if there is organic conductive, mixed, or sensory hearing impairment, and loss of pure tone hearing sensitivity in the low, mid, or high-frequency range or a combination of frequency ranges which contribute to a loss of communication ability; however, hearing aids are to be provided only as needed for the service-connected hearing disability.

(Authority: 38 U.S.C. 1701(6)(A)(i))

[62 FR 30242, June 3, 1997]

### § 17.150 Prosthetic and similar appliances.

Artificial limbs, braces, orthopedic shoes, hearing aids, wheelchairs, medical accessories, similar appliances including invalid lifts and therapeutic and rehabilitative devices, and special clothing made necessary by the wearing of such appliances, may be purchased, made or repaired for any veteran upon a determination of feasibility and medical need, provided:

(a) *As part of outpatient care.* The appliances or repairs are a necessary part of outpatient care for which the veteran is eligible under 38 U.S.C. 1712 and 38 CFR 17.93 (or a necessary part of outpatient care authorized under § 17.94) or

(b) *As part of hospital care.* The appliances or repairs are a necessary part of inpatient care for any service-connected disability or any nonservice-connected disability, if:

(1) The nonservice-connected disability is associated with an aggravating a service-connected disability, or

(2) The nonservice-connected disability is one for which hospital admission was authorized, or

(3) The nonservice-connected disability is associated with and aggravating a nonservice-connected disability for which hospital admission was authorized, or

(4) The nonservice-connected disability is one for which treatment may be authorized under the provisions of § 17.48(f), or

(c) *As part of domiciliary care.* The appliances or repairs are necessary for continued domiciliary care, or are necessary to treat a member's service-connected disability, or nonservice-connected disability associated with and aggravating a service-connected disability, or

(d) *As part of nursing home care.* The appliances or repairs are a necessary part of nursing home care furnished in facilities under the direct and exclusive jurisdiction of the Department of Veterans Affairs.

[32 FR 13816, Oct. 4, 1967, as amended at 33 FR 12315, Aug. 31, 1968; 34 FR 9341, June 13, 1969; 35 FR 17948, Nov. 21, 1970; 54 FR 34983, Aug. 23, 1989. Redesignated and amended at 61 FR 21966, 21968, May 13, 1996]

### § 17.151 Invalid lifts for recipients of aid and attendance allowance or special monthly compensation.

An invalid lift may be furnished if:

(a) The applicant is a veteran who is receiving (1) special monthly compensation (including special monthly compensation based on the need for aid and attendance) under the provisions of 38 U.S.C. 1114(r), or (2) comparable compensation benefits at the rates prescribed under 38 U.S.C. 1134, or (3) increased pension based on the need for aid and attendance or a greater compensation benefit rather than aid and attendance pension to which he or she has been adjudicated to be presently eligible; and

(b) The veteran has loss, or loss of use, of both lower extremities and at least one upper extremity (loss of use may result from paralysis or other impairment to muscle power and includes all cases in which the veteran cannot use his or her extremities or is medically prohibited from doing so because of a serious disease or disability); and

(c) The veteran has been medically determined incapable of moving himself or herself from his or her bed to a wheelchair, or from his or her wheelchair to his or her bed, without the aid of an attendant, because of the disability involving the use of his or her extremities; and

(d) An invalid lift would be a feasible means by which the veteran could accomplish the necessary maneuvers between bed and wheelchair, and is medically determined necessary.

[33 FR 12315, Aug. 31, 1968, as amended at 36 FR 3117, Feb. 13, 1971; 54 FR 34983, Aug. 23, 1989. Redesignated at 61 FR 21966, May 13, 1996]

### § 17.152 Devices to assist in overcoming the handicap of deafness.

Devices for assisting in overcoming the handicap of deafness (including telecaptioning television decoders) may be furnished to any veteran who is profoundly deaf (rated 80% or more disabled for hearing impairment by the Department of Veterans Affairs) and is entitled to compensation on account of such hearing impairment.

(Authority: 38 U.S.C. 3902)

[53 FR 46607, Nov. 18, 1988. Redesignated at 61 FR 21966, May 13, 1996]

### § 17.153 Training in the use of appliances.

Beneficiaries supplied prosthetic and similar appliances will be additionally entitled to fitting and training in the use of the appliances. Such training will usually be given in Department of Veterans Affairs facilities and by Department of Veterans Affairs employees, but may be obtained under contract if determined necessary.

[26 FR 5871, June 30, 1961. Redesignated at 61 FR 21966, May 13, 1996]

### § 17.154 Dog-guides and equipment for blind.

(a) Blind ex-members of the Armed Forces entitled to disability compensation for a service-connected disability may be furnished a trained dog-guide. In addition, they may be furnished necessary travel expense to and from their places of residence to the point where adjustment to the dog-guide is available and meals and lodging during the period of adjustment, provided they are required to be away from their usual places of residence during the period of adjustment.

(b) Mechanical and/or electronic equipment considered necessary as aids to overcoming the handicap of blindness may also be supplied to beneficiaries defined in paragraph (a) of this section.

[26 FR 5872, June 30, 1961. Redesignated at 61 FR 21966, May 13, 1996]

## AUTOMOTIVE EQUIPMENT AND DRIVER TRAINING

### § 17.155 Minimum standards of safety and quality for automotive adaptive equipment.

(a) The Under Secretary for Health or designee is authorized to develop and establish minimum standards of safety and quality for adaptive equipment provided under 38 U.S.C. chapter 39.

(b) In the performance of this function, the following considerations will apply:

(1) Minimum standards of safety and quality will be developed and promulgated for basic adaptive equipment specifically designed to facilitate operation and use of standard passenger motor vehicles by persons who have specified types of disablement and for the installation of such equipment.

(2) In those instances where custom-built adaptive equipment is designed and installed to meet the peculiar needs of uniquely disabled persons and where the incidence of probable usage is not such as to justify development of formal standards, such equipment will be inspected and, if in order, approved for use by a qualified designee of the Under Secretary for Health.

(3) Adaptive equipment, available to the general public, which is manufactured under standards of safety imposed by a Federal agency having authority to establish the same, shall be deemed to meet required standards for use as adaptive equipment. These include such items as automatic transmissions, power brakes, power steering and other automotive options.

(c) For those items where specific Department of Veterans Affairs standards of safety and quality have not as yet been developed, or where such standards are otherwise provided as with custom-designed or factory option items, authorization of suitable adaptive equipment will not be delayed. Approval of such adaptive equipment, however, shall be subject to the judgment of designated certifying officials that it meets implicit standards of

safety and quality adopted by the industry or as later developed by the Department of Veterans Affairs.

[40 FR 8819, Mar. 3, 1975. Redesignated at 61 FR 21966, May 13, 1996, as amended at 62 FR 17072, Apr. 9, 1997]

### § 17.156 Eligibility for automobile adaptive equipment.

Automobile adaptive equipment may be authorized if the Under Secretary for Health or designee determines that such equipment is deemed necessary to insure that the eligible person will be able to operate the automobile or other conveyance in a manner consistent with such person's safety and so as to satisfy the applicable standards of licensure established by the State of such person's residency or other proper licensing authority.

(a) Persons eligible for adaptive equipment are:

(1) Veterans who are entitled to receive compensation for the loss or permanent loss of use of one or both feet; or the loss or permanent loss of use of one or both hands; or ankylosis of one or both knees, or one of both hips if the disability is the result of injury incurred or disease contracted in or aggravated by active military, naval or air service.

(2) Members of the Armed Forces serving on active duty who are suffering from any disability described in paragraph (a)(1) of this section incurred or contracted during or aggravated by active military service are eligible to receive automobile adaptive equipment.

(b) Payment or reimbursement of reasonable costs for the repair, replacement, or reinstallation of adaptive equipment deemed necessary for the operation of the automobile may be authorized by the Under Secretary for Health or designee.

(Authority: 38 U.S.C. 3902)

[53 FR 46607, Nov. 18, 1988. Redesignated at 61 FR 21966, May 13, 1996, as amended at 62 FR 17072, Apr. 9, 1997]

### § 17.157 Definition-adaptive equipment.

The term, adaptive equipment, means equipment which must be part of or added to a conveyance manufactured for sale to the general public to make it safe for use by the claimant, and enable that person to meet the applicable standards of licensure. Adaptive equipment includes any term specified by the Under Secretary for Health or designee as ordinarily necessary for any of the classes of losses or combination of such losses specified in § 17.156 of this part, or as deemed necessary in an individual case. Adaptive equipment includes, but is not limited to, a basic automatic transmission, power steering, power brakes, power window lifts, power seats, air-conditioning equipment when necessary for the health and safety of the veteran, and special equipment necessary to assist the eligible person into or out of the automobile or other conveyance, regardless of whether the automobile or other conveyance is to be operated by the eligible person or is to be operated for such person by another person; and any modification of the interior space of the automobile or other conveyance if needed because of the physical condition of such person in order for such person to enter or operate the vehicle.

(Authority: 38 U.S.C. 3901, 3902)

[53 FR 46608, Nov. 18, 1988. Redesignated and amended at 61 FR 21966, 21968, May 13, 1996]

### § 17.158 Limitations on assistance.

(a) An eligible person shall not be entitled to adaptive equipment for more than two automobiles or other conveyances at any one time or during any four-year period except when due to circumstances beyond control of such person, one of the automobiles or conveyances for which adaptive equipment was provided during the applicable four-year period is no longer available for the use of such person.

(1) Circumstances beyond the control of the eligible person are those where the vehicle was lost due to fire, theft, accident, court action, or when repairs are so costly as to be prohibitive or a different vehicle is required due to a change in the eligible person's physical condition.

(2) For purposes of paragraph (a)(1) of this section, an eligible person shall be deemed to have access to and use of an automobile or other conveyance for

which the Department of Veterans Affairs has provided adaptive equipment if that person has sold, given or transferred the vehicle to a spouse, family member or other person residing in the same household as the eligible person, or to a business owned by such person.

(Authority: 38 U.S.C. 3903)

(b) Eligible persons may be reimbursed for the actual cost of adaptive equipment subject to a dollar amount for specific items established from time to time by the Under Secretary for Health.

(Authority: 38 U.S.C. 3902)

(c) Reimbursement for a repair to an item of adaptive equipment is limited to the current vehicles of record and only to the basic components authorized as automobile adaptive equipment. Reimbursable amounts for repairs are limited to the cost of parts and labor based on the amounts published in generally acceptable commercial estimating guides for domestic automobiles.

(Authority: 38 U.S.C. 3902)

[53 FR 46608, Nov. 18, 1988. Redesignated and amended at 61 FR 21966, 21968, May 13, 1996]

### § 17.159 Obtaining vehicles for special driver training courses.

The Secretary may obtain by purchase, lease, gift or otherwise, any automobile, motor vehicle, or other conveyance deemed necessary to conduct special driver training courses at Department of Veterans Affairs health care facilities. The Secretary may sell, assign, transfer or convey any such automobile, vehicle or conveyance to which the Department of Veterans Affairs holds title for such price or under such terms deemed appropriate by the Secretary. Any proceeds received from such disposition shall be credited to the applicable Department of Veterans Affairs appropriation.

(Authority: 38 U.S.C. 3903(e)(3))

[45 FR 6939, Jan. 31, 1980. Redesignated at 54 FR 46607, Nov. 18, 1988, and further redesignated at 61 FR 21966, May 13, 1996]

## DENTAL SERVICES

### § 17.160 Authorization of dental examinations.

When a detailed report of dental examination is essential for a determination of eligibility for benefits, dental examinations may be authorized for the following classes of claimants or beneficiaries:

(a) Those having a dental disability adjudicated as incurred or aggravated in active military, naval, or air service or those requiring examination to determine whether the dental disability is service connected.

(b) Those having disability from disease or injury other than dental, adjudicated as incurred or aggravated in active military, naval, or air service but with an associated dental condition that is considered to be aggravating the basic service-connected disorder.

(c) Those for whom a dental examination is ordered as a part of a general physical examination.

(d) Those requiring dental examination during hospital, nursing home, or domiciliary care.

(e) Those held to have suffered dental injury or aggravation of an existing dental injury, as the result of examination, hospitalization, or medical or surgical (including dental) treatment that had been awarded.

(f) Veterans who are participating in a rehabilitation program under 38 U.S.C. chapter 31 are entitled to such dental services as are professionally determined necessary for any of the reasons enumerated in § 17.47(g).

(Authority: 38 U.S.C. 1712(b); ch. 31)

(g) Those for whom a special dental examination is authorized by the Under Secretary for Health or the Assistant Chief Medical Director for Dentistry.

(h) Persons defined in § 17.60(d).

[13 FR 7162, Nov. 27, 1948, as amended at 21 FR 10388, Dec. 28, 1956; 23 FR 6503, Aug. 22, 1958; 27 FR 11424, Nov. 20, 1962; 29 FR 1463, Jan. 29, 1964; 30 FR 1789, Feb. 9, 1965; 32 FR 13817, Oct. 4, 1967; 33 FR 5300, Apr. 3, 1968; 35 FR 6586, Apr. 24, 1970; 49 FR 5617, Feb. 14, 1984. Redesignated and amended at 61 FR 21966, 21968, May 13, 1996]

**§ 17.161 Authorization of outpatient dental treatment.**

Outpatient dental treatment may be authorized by the Chief, Dental Service, for beneficiaries defined in 38 U.S.C. 1712(b) and 38 CFR 17.93 to the extent prescribed and in accordance with the applicable classification and provisions set forth in this section.

(a) *Class I.* Those having a service-connected compensable dental disability or condition, may be authorized any dental treatment indicated as reasonably necessary to maintain oral health and masticatory function. There is no time limitation for making application for treatment and no restriction as to the number of repeat episodes of treatment.

(b) *Class II.* (1)(i) Those having a service-connected noncompensable dental condition or disability shown to have been in existence at time of discharge or release from active service, which took place after September 30, 1981, may be authorized any treatment indicated as reasonably necessary for the one-time correction of the service-connected noncompensable condition, but only if:

(A) They served on active duty during the Persian Gulf War and were discharged or released, under conditions other than dishonorable, from a period of active military, naval, or air service of not less than 90 days, or they were discharged or released under conditions other than dishonorable, from any other period of active military, naval, or air service of not less than 180 days;

(B) Application for treatment is made within 90 days after such discharge or release.

(C) The certificate of discharge or release does not bear a certification that the veteran was provided, within the 90-day period immediately before such discharge or release, a complete dental examination (including dental X-rays) and all appropriate dental treatment indicated by the examination to be needed, and

(D) Department of Veterans Affairs dental examination is completed within six months after discharge or release, unless delayed through no fault of the veteran.

(ii) Those veterans discharged from their final period of service after August 12, 1981, who had reentered active military service within 90 days after the date of a discharge or release from a prior period of active military service, may apply for treatment of service-connected noncompensable dental conditions relating to any such periods of service within 90 days from the date of their final discharge or release.

(iii) If a disqualifying discharge or release has been corrected by competent authority, application may be made within 90 days after the date of correction.

(2)(i) Those having a service-connected noncompensable dental condition or disability shown to have been in existence at time of discharge or release from active service, which took place before October 1, 1981, may be authorized any treatment indicated as reasonably necessary for the one-time correction of the service-connected noncompensable condition, but only if:

(A) They were discharged or released, under conditions other than dishonorable, from a period of active military, naval or air service of not less than 180 days.

(B) Application for treatment is made within one year after such discharge or release.

(C) Department of Veterans Affairs dental examination is completed within 14 months after discharge or release, unless delayed through no fault of the veteran.

(ii) Those veterans discharged from their final period of service before August 13, 1981, who had reentered active military service within one year from the date of a prior discharge or release, may apply for treatment of service-connected noncompensable dental conditions relating to any such prior periods of service within one year of their final discharge or release.

(iii) If a disqualifying discharge or release has been corrected by competent authority, application may be made within one year after the date of correction.

(Authority: 38 U.S.C. 1712)

(c) *Class II* (*a*). Those having a service-connected noncompensable dental condition or disability adjudicated as resulting from combat wounds or service trauma may be authorized any

treatment indicated as reasonably necessary for the correction of such service-connected noncompensable condition or disability.

(d) *Class II(b).* Those having a service-connected noncompensable dental condition or disability and who had been detained or interned as prisoners of war for a period of less than 90 days may be authorized any treatment as reasonably necessary for the correction of such service-connected dental condition or disability.

(Authority: Pub. L. 100–322; 38 U.S.C. 1712(b)(l)(F))

(e) *Class II(c).* Those who were prisoners of war for 90 days or more, as determined by the concerned military service department, may be authorized any needed dental treatment.

(Authority: Pub. L. 100–322, 38 U.S.C. 1712(b)(1)(F))

(f) *Class IIR (Retroactive).* Any veteran who had made prior application for and received dental treatment from the Department of Veterans Affairs for noncompensable dental conditions, but was denied replacement of missing teeth which were lost during any period of service prior to his/her last period of service may be authorized such previously denied benefits under the following conditions:

(1) Application for such retroactive benefits is made within one year of April 5, 1983.

(2) Existing Department of Veterans Affairs records reflect the prior denial of the claim.

All Class IIR (Retroactive) treatment authorized will be completed on a fee basis status.

(Authority: 38 U.S.C. 1712)

(g) *Class III.* Those having a dental condition professionally determined to be aggravating disability from an associated service-connected condition or disability may be authorized dental treatment for only those dental conditions which, in sound professional judgment, are having a direct and material detrimental effect upon the associated basic condition or disability.

(h) *Class IV.* Those whose service-connected disabilities are rated at 100% by schedular evaluation or who are entitled to the 100% rate by reason of individual unemployability may be authorized any needed dental treatment.

(Authority: 38 U.S.C. 1712)

(i) *Class V.* A veteran who is participating in a rehabilitation program under 38 U.S.C. chapter 31 may be authorized such dental services as are professionally determined necessary for any of the reasons enumerated in § 17.47(g).

(Authority: 38 U.S.C. 1712(b); chapter 31)

(j) *Class VI.* Any veterans scheduled for admission or otherwise receiving care and services under chapter 17 of 38 U.S.C. may receive outpatient dental care which is medically necessary, i.e., is for dental condition clinically determined to be complicating a medical condition currently under treatment.

(Authority: 38 U.S.C. 1712)

[20 FR 9505, Dec. 20, 1955, as amended at 26 FR 11214, Nov. 28, 1961; 27 FR 11424, Nov. 20, 1962; 29 FR 18219, Dec. 23, 1964; 32 FR 13817, Oct. 4, 1967; 33 FR 5300, Apr. 3, 1968; 45 FR 47680, July 16, 1980; 48 FR 16681, Apr. 19, 1983; 49 FR 5617, Feb. 14, 1984; 54 FR 25449, June 15, 1989; 57 FR 4367, Feb. 5, 1992; 57 FR 41701, Sept. 11, 1992. Redesignated and amended at 61 FR 21965, 21968, May 13, 1996]

### § 17.162 Eligibility for Class II dental treatment without rating action.

When an application has been made for class II dental treatment under § 17.161(b), the applicant may be deemed eligible and dental treatment authorized on a one-time basis without rating action if:

(a) The examination to determine the need for dental care has been accomplished within the specified time limit after date of discharge or release unless delayed through no fault of the veteran, and sound dental judgment warrants a conclusion the condition originated in or was aggravated during service and the condition existed at the time of discharge or release from active service, and

(Authority: 38 U.S.C. 1712)

(b) The treatment will not involve replacement of a missing tooth noted at the time of Department of Veterans Affairs examination except:

(1) In conjunction with authorized extraction replacement, or

(2) When a determination can be made on the basis of sound professional judgment that a tooth was extracted or lost on active duty.

(c) Individuals whose entire tour of duty consisted of active or inactive duty for training shall not be eligible for treatment under this section.

[37 FR 6847, Apr. 5, 1972, as amended at 48 FR 16682, Apr. 19, 1983. Redesignated and amended at 61 FR 21966, 21968, May 13, 1996]

### § 17.163 Posthospital outpatient dental treatment.

The Chief, Dental Service may authorize outpatient dental care which is reasonably necessary to complete treatment of a nonservice-connected dental condition which was begun while the veteran was receiving Department of Veterans Affairs authorized hospital care.

(Authority: 38 U.S.C. 1712(b)(5))

[45 FR 6939, Jan. 31, 1980. Redesignated at 61 FR 21966, May 13, 1996]

### § 17.164 Patient responsibility in making and keeping dental appointments.

Any veteran eligible for dental treatment on a one-time completion basis only and who has not received such treatment within 3 years after filing the application shall be presumed to have abandoned the claim for dental treatment.

[45 FR 6939, Jan. 31, 1980. Redesignated at 61 FR 21966, May 13, 1996]

### § 17.165 Emergency outpatient dental treatment.

When outpatient emergency dental care is provided, as a humanitarian service, to individuals who have no established eligibility for outpatient dental care, the treatment will be restricted to the alleviation of pain or extreme discomfort, or the remediation of a dental condition which is determined to be endangering life or health. The provision of emergency treatment to persons found ineligible for dental care will not entitle the applicant to further dental treatment. Individuals provided emergency dental care who are found to be ineligible for such care will be billed.

(Authority: 38 U.S.C. 501)

[50 FR 14704, Apr. 15, 1985; 50 FR 21604, May 28, 1985. Redesignated at 61 FR 21966, May 13, 1996]

### § 17.166 Dental services for hospital or nursing home patients and domiciled members.

Persons receiving hospital, nursing home, or domiciliary care pursuant to the provisions of §§ 17.46 and 17.47, will be furnished such dental services as are professionally determined necessary to the patients' or members' overall hospital, nursing home, or domiciliary care.

[30 FR 1790, Feb. 9, 1965. Redesignated at 61 FR 21966, May 13, 1996]

## AUTOPSIES

### § 17.170 Autopsies.

(a) Except as provided in this section, no autopsy will be performed by the Department of Veterans Affairs unless there is no known surviving spouse or known next of kin; or without the consent of the surviving spouse or, in a proper case, the next of kin, unless the patient or domiciled person was abandoned by the spouse, if any, or, if no spouse, by the next of kin for a period of not less than 6 months next preceding death. Where no inquiry has been made for or in regard to the decedent for a period of 6 months next preceding his death, he or she shall be deemed to have been abandoned.

(b) If there is no known surviving spouse or known next of kin, or if the decedent shall have been abandoned or if the request is sent and the spouse or, in proper cases, the next of kin fails to reply within the reasonable time stated in such request of the Department of Veterans Affairs for permission to perform the autopsy, the Director is hereby authorized to cause an autopsy to be performed if in the Director's discretion he or she concludes that such autopsy is reasonably required for any necessary purpose of the Department of Veterans Affairs, including the completion of official records and advancement of medical knowledge.

(c) If it is suspected that death resulted from crime and if the United

States has jurisdiction over the area where the body is found, the Director of the Department of Veterans Affairs facility will inform the appropriate Regional Counsel of the known facts concerning the death. Thereupon the Regional Counsel will transmit all such information to the United States Attorney for such action as may be deemed appropriate and will inquire whether the United States Attorney objects to an autopsy if otherwise it be appropriate. If the United States Attorney has no objection, the procedure as to autopsy will be the same as if the death had not been reported to him or her.

(d) If the United States does not have exclusive jurisdiction over the area where the body is found the local medical examiner/coroner will be informed. If the local medical examiner/coroner declines to assume jurisdiction the procedure will be the same as is provided in paragraph (c) of this section. If a Federal crime is indicated by the evidence, the procedure of paragraph (c) of this section will also be followed.

(e) The laws of the decedent's domicile are determinative as to whether the spouse or the next of kin is the proper person to grant permission to perform an autopsy and of the question as to the order of preference among such persons. Usually the spouse is first entitled, except in some situations of separation; followed by children, parents, brothers and sisters, etc. When the next of kin as defined by the laws of decedent's domicile consists of a number of persons as children, parents, brothers and sisters, etc., permission to perform an autopsy may be accepted when granted by the person in the appropriate class who assumes the right and duty of burial.

(f) The Director of a Department of Veterans Affairs facility is authorized to cause an autopsy to be performed on a veteran who dies outside of a Department of Veterans Affairs facility while undergoing post-hospital care under the provisions of 38 U.S.C. 1712 and 38 CFR 17.93, if the Director determines such autopsy is reasonably required for any necessary purpose of the Department of Veterans Affairs, including the completion of official records and advancement of medical knowledge. Such authority also encompasses the furnishing of transportation of the body at Department of Veterans Affairs expense to the Department of Veterans Affairs facility and return of the body. Consent for the autopsy will be obtained as provided for in paragraph (e) of this section.

[16 FR 5701, June 15, 1951, as amended at 18 FR 2414, Apr. 24, 1953; 24 FR 8330, Oct. 14, 1959; 35 FR 6586, Apr. 24, 1970; 36 FR 23386, Dec. 9, 1971; 45 FR 6939, Jan. 31, 1980. Redesignated and amended at 61 FR 21966, 21968, May 13, 1996; 61 FR 29294, June 10, 1996]

## VETERANS CANTEEN SERVICE

### § 17.180 Delegation of authority.

In connection with the Veterans Canteen Service, the Under Secretary for Health is hereby delegated authority as follows:

(a) To exercise the powers and functions of the Secretary with respect to the maintenance and operation of the Veterans Canteen Service.

(b) To designate the Assistant Chief Medical Director for Administration to administer the overall operation of the Veterans Canteen Service and to designate selected employees of the Veterans Canteen Service to perform the functions described in the enabling statute, 38 U.S.C. ch. 75, so as to effectively maintain and operate the Veterans Canteen Service.

[20 FR 337, Jan. 14, 1955, as amended at 36 FR 23386, Dec. 9, 1971; 45 FR 6939, Jan 31, 1980. Redesignated at 61 FR 21966, May 13, 1996, as amended at 62 FR 17072, Apr. 9, 1997]

## AID TO STATES FOR CARE OF VETERANS IN STATE HOMES

NOTE: Sections 17.190 through 17.200 do not apply to nursing home care in State homes. The provisions for nursing home care in State homes are set forth in 38 CFR part 51.

### § 17.190 Recognition of a State home.

A State-operated facility which provides hospital or domiciliary care to veterans must be formally recognized by the Secretary as a State home before Federal aid payments can be made for the care of such veterans. Any agency of a State (exclusive of a territory or possession) responsible for the maintenance or administration of a State home may apply for recognition

by the Department of Veterans Affairs for the purpose of receiving aid for the care of veterans in such State home. A State home may be recognized if:

(Authority: 38 U.S.C. 501, 1741)

(a) The State home is a facility which exists primarily for the accommodation of veterans incapable of earning a living and who are in need of domiciliary, and

(b) The majority of such veterans who are domiciliary members in the home are veterans who may be included in the computation of the amount of aid payable from the Department of Veterans Affairs, and

(c) The personnel, building and other facilities and improvements at the home are devoted primarily to the care of veterans, and

[35 FR 3166, Feb. 19, 1970, as amended at 45 FR 6939, Jan. 31, 1980. Redesignated and amended at 61 FR 21966, 21968, May 13, 1996; 65 FR 968, Jan. 6, 2000]

### § 17.191 Filing applications.

Applications for Department of Veterans Affairs recognition of a State home may be filed with the Under Secretary for Health, Department of Veterans Affairs. After arranging for an inspection of the State home's facilities for furnishing domiciliary or hospital care, the Under Secretary for Health will make a recommendation to the Secretary who will notify the State official in writing of a decision.

[35 FR 3166, Feb. 19, 1970, as amended at 45 FR 6939, Jan. 31, 1980. Redesignated and amended at 61 FR 21966, 21968, May 13, 1996; 65 FR 968, Jan. 6, 2000]

### § 17.192 Approval of annexes and new facilities.

Separate applications for recognition must be filed for any annex, branch, enlargement, expansion, or relocation of a recognized home which is not on the same or contiguous grounds on which the parent facility is located. When a recognized State home establishes hospital care facilities which have not been inspected and approved by the Department of Veterans Affairs, a request for separate approval of such facilities must be made.

(Authority: 38 U.S.C. 1741, 501)

[35 FR 3166, Feb. 19, 1970, as amended at 45 FR 6939, Jan. 31, 1980. Redesignated and amended at 61 FR 21966, 21968, May 13, 1996; 65 FR 968, Jan. 6, 2000]

### § 17.193 Prerequisites for payments to State homes.

No payment or grant may be made to any State home unless the State home meets the standards prescribed by the Secretary.

(Authority: 38 U.S.C. 1742(a))

[45 FR 6939, Jan. 31, 1980. Redesignated at 61 FR 21966, May 13, 1996; 65 FR 968, Jan. 6, 2000]

### § 17.194 Aid for domiciliary care.

Aid may be paid to the designated State official for domiciliary care furnished in a recognized State home for any veteran if the veteran is eligible for domiciliary care in a Department of Veterans Affairs facility.

(Authority: 38 U.S.C. 1741)

[45 FR 6939, Jan. 31, 1980. Redesignated at 61 FR 21966, May 13, 1996]

### § 17.196 Aid for hospital care.

Aid may be paid to the designated State official for hospital care furnished in a recognized State home for any veteran if:

(a) The veteran is eligible for hospital care in a Department of Veterans Affairs facility, and

(b) The quarters in which the hospital care is carried out are in an area clearly designated for such care, specifically established, staffed and equipped to provide hospital type care, are not intermingled with the quarters of nursing home care patients or domiciliary members, and meet such other minimum standards as the Department of Veterans Affairs may prescribe.

[45 FR 6940, Jan. 31, 1980. Redesignated at 61 FR 21966, May 13, 1996]

### § 17.197 Amount of aid payable.

The amount of aid payable to a recognized State home shall be at the per diem rates established by title 38 U.S.C., section 1741(a)(1) for domiciliary care; and section 1741(a)(3) for

hospital care. In no case shall the payments made with respect to any veteran exceed one-half of the cost of the veteran's care in the State home. VA will publish the actual per diem rates, whenever they change, in a FEDERAL REGISTER notice.

(Authority: 38 U.S.C. 1741)

[50 FR 32568, Aug. 13, 1985. Redesignated at 61 FR 21966, May 13, 1996; 65 FR 968, Jan. 6, 2000]

### § 17.198 Department of Veterans Affairs approval of eligibility required.

Federal aid will be paid only for the care of veterans whose separate eligibility for hospital or domiciliary care has been approved by the Department of Veterans Affairs. To obtain such approval, State homes will complete a Department of Veterans Affairs application form for each veteran for the type of care to be provided and submit it to the Department of Veterans Affairs office of jurisdiction for determination of eligibility. Payments shall be made only from the date the Department of Veterans Affairs office of jurisdiction receives such application; however, if such request is received by the Department of Veterans Affairs office of jurisdiction within 10 days after the beginning of the care of such veteran for which he or she is determined to be eligible, payment shall be made on account of such veteran from the date care began.

(Authority: 38 U.S.C. 1743)

[35 FR 3167, Feb. 19, 1970, as amended at 45 FR 6940, Jan. 31, 1980. Redesignated at 61 FR 21966, May 13, 1996; 65 FR 968, Jan. 6, 2000]

### § 17.199 Inspection of recognized State homes.

Representatives of the Department of Veterans Affairs may inspect any State home at such times as are deemed necessary. Such inspections shall be concerned with the physical plant; records relating to admissions, discharges and occupancy; fiscal records; and all other areas of interest necessary to a determination of compliance with applicable laws and regulations relating to the payment of Federal aid. The authority to inspect carries with it no authority over the management or control of any State home.

(Authority: 38 U.S.C. 1742)

[30 FR 221, Jan. 8, 1965, as amended at 35 FR 3167, Feb. 19, 1970. Redesignated at 61 FR 21966, May 13, 1996]

### § 17.200 Audit of State homes.

The State must comply with the Single Audit Act of 1984 (part 41 of this chapter).

(Authority: 31 U.S.C. 7501–7507)

[52 FR 23825, June 25, 1987. Redesignated at 61 FR 21966, May 13, 1996]

## GRANTS TO STATES FOR CONSTRUCTION OR ACQUISITION OF STATE HOME FACILITIES

NOTE: The purpose of the regulations concerning grants to States for construction or acquisition of State home facilities is to effectuate the provisions of 38 U.S.C. 8131–8137 and to assist the several States to construct or acquire State home facilities for furnishing domiciliary or nursing home care to veterans, and to expand, remodel, or alter existing buildings for furnishing domiciliary, nursing home or hospital care to veterans in State homes.

### § 17.210 Definitions.

For the purpose of the regulations concerning grants to States for construction or acquisition of State home facilities:

(a) The veteran population of each State shall be determined on the basis of the latest figures certified by the Department of Commerce.

(Authority: 38 U.S.C. 8131(a))

(b) The term *State* means each of the several States, the District of Columbia, the Virgin Islands, and the Commonwealth of Puerto Rico.

(Authority: 38 U.S.C. 8131(b))

(c) The term *construction* means the construction of new domiciliary or nursing home buildings, the expansion, remodeling, or alteration of existing buildings for the provision of domiciliary, nursing home, or hospital care in State homes and the provision of initial equipment for any such buildings. The term includes necessary support systems and work performed over and above that required for maintenance and repair. Generally, facilities

such as parking lots, landscaping, sidewalks, streets, storm sewers, etc., are excluded except to the extent the work is inextricably involved with new construction or the remodeling, modification or alteration of existing facilities.

(Authority: 38 U.S.C. 8131(c))

(d) The term *cost of construction* means the amount which the Secretary determines to be necessary for a State home construction project, including architect fees, supervision and site inspection services, printing and advertising costs, but excluding land acquisition costs.

(Authority: 38 U.S.C. 8131(d))

(e) The term *State agency* means that State agency or instrumentality of a State designated by a State as authorized to apply for assistance to construct or acquire State home facilities for veterans and thereafter administer those facilities.

(f) The term *acquisition* means the purchase of a facility for use as a State veterans home for the provision of domiciliary and/or nursing home care to veterans. An acquisition includes any remodeling or alteration needed to meet existing standards.

(g) The term *cost of acquisition* means the amount which the Secretary determines to be necessary to acquire and renovate a facility for the provision of domiciliary or nursing home care as a State home.

(h) As used in connection with a request from a State for a grant to assist in the construction or acquisition of a State veterans home:

(1) The term *preapplication* means the State's submission to the Secretary of a preapplication for Federal Assistance on Standard Form 424 with an accompanying space program and schematics for the project; and

(2) The term *application* means the submission to the Secretary of an application for Federal Assistance for a project on Standard Form 424 after the Department of Veterans Affairs has reviewed the State's preapplication for the project and informed the State that it is a feasible project for Federal participation.

(i) The term *life safety project* means a State veterans nursing home or domiciliary project which would remedy an existing condition which has been cited by the Department of Veterans Affairs, a State or local agency (including a Fire Marshal), or the Joint Commission on Accreditation of Hospitals, as threatening to the lives or safety of patients within the facility.

(j) The term *renovation project* means a project to expand, remodel or alter a State veterans nursing home or domiciliary which is not a life safety project and does not result in the addition of domiciliary or nursing home beds.

[45 FR 38357, June 9, 1980, as amended at 52 FR 23825, June 25, 1987; 56 FR 20353, May 3, 1991. Redesignated at 61 FR 21966, May 13, 1996]

### § 17.211 Maximum number of nursing home beds for veterans by State.

(a) For purposes of these regulations, appendix A prescribes the maximum number of beds which may be necessary to provide adequate nursing home care and domiciliary care to veterans residing in each State. When the nursing home beds to be constructed or acquired in a State will result in more than 2½ beds per 1,000 veterans, the State shall provide sufficient justification for the Secretary to determine that the additional beds are required in that State. In making this determination, the Secretary shall consider the following factors: (1) Demographic characteristics of the State's veteran population, (2) availability, suitability and cost of alternative nursing home beds to meet the needs of veterans in the State, (3) waiting lists for existing State nursing home facilities and (4) any other criteria which the Secretary shall deem appropriate to provide adequate nursing home care.

(Authority: 38 U.S.C. 8134(1))

(b) At the time an application is filed by a State for a grant under the regulations concerning grants to States for construction of State home facilities, such State must submit a certified statement listing the total number of State-operated nursing home care beds for veterans together with all other State projects under construction for beds to furnish nursing home care to veterans in such State.

(Authority: 38 U.S.C. 8135(a)(3))

APPENDIX A TO § 17.211—STATE HOME FACILITIES FOR FURNISHING NURSING HOME CARE

The maximum number of beds to provide adequate nursing home care and domiciliary care to veterans residing in each State not to exceed four beds per 1,000 veteran population for nursing home care and two beds per 1,000 veteran population for domiciliary care is established as follows:

| State | Veteran population in thousands | No. of beds: NHC 2.5/1000 | No. of beds: NHC 4/1000 | No. of beds: Dom 2/1000 |
|---|---|---|---|---|
| Alabama | 405 | 1,013 | 1,620 | 810 |
| Alaska | 63 | 158 | 252 | 126 |
| Arizona | 420 | 1,050 | 1,680 | 840 |
| Arkansas | 252 | 630 | 1,008 | 504 |
| California | 2,829 | 7,073 | 11,316 | 5,658 |
| Colorado | 395 | 988 | 1,580 | 790 |
| Connecticut | 386 | 965 | 1,544 | 772 |
| Delaware | 80 | 200 | 320 | 160 |
| District of Columbia | 57 | 143 | 228 | 114 |
| Florida | 1,524 | 3,810 | 6,096 | 3,048 |
| Georgia | 666 | 1,665 | 2,664 | 1,332 |
| Hawaii | 100 | 250 | 400 | 200 |
| Idaho | 109 | 273 | 436 | 218 |
| Illinois | 1,227 | 3,068 | 4,908 | 2,454 |
| Indiana | 640 | 1,600 | 2,560 | 1,280 |
| Iowa | 325 | 813 | 1,300 | 650 |
| Kansas | 282 | 705 | 1,128 | 564 |
| Kentucky | 359 | 898 | 1,436 | 718 |
| Louisiana | 417 | 1,043 | 1,668 | 834 |
| Maine | 154 | 385 | 616 | 308 |
| Maryland | 543 | 1,358 | 2,172 | 1,086 |
| Massachusetts | 666 | 1,665 | 2,664 | 1,332 |
| Michigan | 1,026 | 2,565 | 4,104 | 2,052 |
| Minnesota | 496 | 1,240 | 1,984 | 992 |
| Mississippi | 230 | 575 | 920 | 460 |
| Missouri | 629 | 1,573 | 2,516 | 1,258 |
| Montana | 100 | 250 | 400 | 200 |
| Nebraska | 178 | 445 | 712 | 356 |
| Nevada | 146 | 365 | 584 | 292 |
| New Hampshire | 146 | 365 | 584 | 292 |
| New Jersey | 875 | 2,188 | 3,500 | 1,750 |
| New Mexico | 170 | 425 | 680 | 340 |
| New York | 1,801 | 4,503 | 7,204 | 3,602 |
| North Carolina | 681 | 1,703 | 2,724 | 1,362 |
| North Dakota | 63 | 158 | 252 | 126 |
| Ohio | 1,296 | 3,240 | 5,184 | 2,592 |
| Oklahoma | 378 | 945 | 1,512 | 756 |
| Oregon | 356 | 890 | 1,424 | 712 |
| Pennsylvania | 1,508 | 3,770 | 6,032 | 3,016 |
| Rhode Island | 119 | 298 | 476 | 238 |
| South Carolina | 354 | 885 | 1,416 | 708 |
| South Dakota | 77 | 193 | 308 | 154 |
| Tennessee | 530 | 1,325 | 2,120 | 1,060 |
| Texas | 1,747 | 4,368 | 6,988 | 3,494 |
| Utah | 140 | 350 | 560 | 280 |
| Vermont | 64 | 160 | 256 | 128 |
| Virginia | 664 | 1,660 | 2,656 | 1,328 |
| Washington | 598 | 1,495 | 2,392 | 1,196 |
| West Virginia | 217 | 543 | 868 | 434 |
| Wisconsin | 561 | 1,403 | 2,244 | 1,122 |
| Wyoming | 54 | 135 | 216 | 108 |
| Puerto Rico | 124 | 310 | 496 | 248 |

Estimate as of March 31, 1989.

Source: Office of Reports and Statistics, VA. (Based on last available Bureau of the Census data.)

[45 FR 38357, June 9, 1980, as amended at 48 FR 1490, Jan. 13, 1983; 52 FR 23826, 23829, June 25, 1987; 56 FR 20353, May 3, 1991. Redesignated at 61 FR 21966, May 13, 1996]

### § 17.212 Scope of grants program.

(a) Subject to the availability of an appropriation, a grant may be made to

a State which has submitted an application for assistance to construct (or to acquire) State home facilities (if the application has been approved by the Secretary) as prescribed in 38 U.S.C. 8131 through 8137 and §§17.210 through 17.216.

(b) The Department of Veterans Affairs may offer a State a grant which is less than the amount of the grant requested subject to the State's provision of assurance that adequate financial support will be available for the project and for its maintenance, repair, and operation when complete. If VA offers a grant to a State for less than the amount requested and the State refuses to accept it, these Federal funds will be applied to other applications which have met all Federal requirements in the order of their priority on the list which was established by the Secretary under §17.213(d) of this part for that fiscal year.

(c) If a State accepts the grant for less than the amount requested, the State may request that its application for additional funds be ranked on the next priority list for additional Federal funds.

(d)(1) Notwithstanding paragraph (c) of this section and the provisions for ranking projects within a priority group in §17.213(c)(3)(i), the Secretary shall give an application first priority within the priority group to which it is assigned on the list of projects established under §17.213(d) for the next fiscal year if:

(i) The State has accepted a grant for that application as of August 15 of the current fiscal year that is less than the amount that the Secretary would have awarded if VA had sufficient grant funds to award the grant in such amount in that fiscal year; and

(ii) The application is the lowest ranking application on the priority list for the current fiscal year for which grant funds are available as of August 15 of that year.

(2) The Secretary shall not require a State to submit a second grant application for a project which receives priority under paragraph (d)(1) of this section but may require the State to update information already submitted in the application for the project. The Secretary shall determine the amount of a second grant at the time of the award of that grant. In no case shall the total amount awarded for the application exceed 65 percent of the total cost of the project as determined at the time of the second grant award for that grant application.

(Authority: 38 U.S.C. 8135(b))

[52 FR 23826, June 25, 1987, as amended at 56 FR 20354, May 3, 1991. Redesignated and amended at 61 FR 21966, 21968, May 13, 1996; 62 FR 60783, Nov. 13, 1997]

### §17.213 Applications with respect to projects.

(a) A State desiring to receive Federal assistance for construction or acquisition of a State home facility shall submit to the Secretary a preapplication (if the need for Federal funding exceeds $100,000) and an application for such assistance in compliance with the uniform requirements for grant-in-aid to State and local governments prescribed in the Office of Management and Budget Circular No. A–102, Revised. The applicant will submit as part of the application or as an attachment thereto:

(1) The amount of the grant requested with respect to such project which may not exceed 65 percent of the estimated cost of construction or acquisition and construction of such project.

(2) A description of the site for such project.

(3) Plans and specifications as required by 38 U.S.C. 8135 and 38 CFR 17.210 through 17.216.

(4) Any comments or recommendations made by appropriate State (and areawide) clearinghouses pursuant to policies outlined in Executive Order 12372, Intergovernmental Review of Federal Programs (part 40 of this chapter).

(5) The State application for Federal assistance shall include environmental documentation for the project by submitting a Categorical Exclusion (CE), Environmental Assessment (EA), or an Environmental Impact Statement (EIS). The environmental documentation will require approval by the Department of Veterans Affairs before final award of a construction or acquisition grant for a State veterans home.

(See §26.6 of this chapter for compliance requirements.) If the proposed actions involving construction or acquisition do not individually or cumulatively have a significant effect on the human environment, the applicant shall submit a letter noting a Categorical Exclusion. If construction outside the walls of an existing structure will involve more than 75,000 gross square feet (GSF), the application shall include an environmental assessment to determine if an Environmental Impact Statement is necessary for compliance with section 102(2)(c) of the National Environmental Policy Act of 1969. When the application submission requires an environmental assessment, the State shall briefly describe the possible beneficial and/or harmful effect which the project may have on the following impact categories:

(i) Transportation;
(ii) Air quality;
(iii) Noise;
(iv) Solid waste;
(v) Utilities;
(vi) Geology (soils/hydrology/flood plains);
(vii) Water quality;
(viii) Land use;
(ix) Vegetation, wildlife, aquatic, and ecology/wetlands;
(x) Economic activities;
(xi) Cultural resources;
(xii) Aesthetics;
(xiii) Residential population;
(xiv) Community services and facilities;
(xv) Community plans and projects; and
(xvi) Other.

If an adverse environmental impact is anticipated, the action to be taken to minimize the impact should be explained in the environmental assessment.

(Authority: 38 U.S.C. 8135(a))

(b) The applicant must furnish reasonable assurance that:

(1) Upon completion of such project the facilities will be used principally to furnish to veterans the level of care for which such application is made, and that not more than 25 per centum of the bed occupancy at any one time will consist of patients who are not receiving such level of care as veterans, and that such level of care will meet the standards prescribed by the Secretary.

(2) Title to such site is or will be vested solely in the applicant, State home, or other agency or instrumentality of the State.

(3) Adequate financial support will be available for the construction of the project, and for its maintenance, repair and operation when complete.

(4) The State will make such reports in such form and containing such information as the Secretary may from time to time reasonably require, and give the Secretary, upon demand, access to the records upon which such information is based.

(5) The rates of pay for laborers and mechanics engaged in construction of the project will not be less than the prevailing local wage rates for similar work as determined in accordance with the Act of March 3, 1931 (40 U.S.C. 276a through 276a–5) known as the Davis-Bacon Act.

(Authority: 38 U.S.C. 8135(a)(8))

(6) Contractors engaged in the construction of the project will be required to comply with the provisions of Executive Order 11246 of September 24, 1965 (30 FR 12319), as amended by Executive Order 11375 of October 13, 1967 (32 FR 14303), and by Executive Order 12086 of October 5, 1978 (43 FR 46501), and rules, regulations, or orders as the Secretary of Labor may issue or adopt.

(7) Grantees will comply with the Federal requirements contained in title 38, Code of Federal Regulations, parts 43 and 44 and assurances contained in SF–424D, Assurances-Construction Programs.

(Authority: 38 U.S.C. 8135(a))

(8) The structures constructed will be of fire, earthquake, and other natural disaster resistant construction.

(Authority: 38 U.S.C. 8105)

(9) In the case of a project for acquisition of a facility, the State agency must provide reasonable assurance that the total cost of acquisition of the facility, including any expansion, remodeling and alteration to meet all building requirements and codes, and for all other purposes, shall not be

greater than the estimated cost of construction of an equivalent new State home facility.

(Authority: 38 U.S.C. 8135(a)(9))

(10) An audit will be performed in compliance with the Single Audit Act of 1984 (See part 41 of this chapter).

(Authority: 31 U.S.C. 7501–7507)

(c) Upon receipt of an application for a grant for a project for construction or acquisition of a State veterans home, the Secretary or designee shall:

(1) Determine whether the application meets the requirements of 38 U.S.C. 8135 and §§17.210 through 17.216 and appendix A to §17.211 of this title and whether the application contains sufficient information for the Secretary to establish its priority. The Secretary shall consider the following factors when making a determination for purposes of this section that a project is primarily a State veterans nursing home, domiciliary or hospital project:

(i) The number of State veterans nursing home, domiciliary, and/or hospital beds that would be constructed or acquired by the project;

(ii) The amount of nursing home, domiciliary, or hospital project space that will result from the construction or acquisition project;

(iii) The estimated number of veteran patients who would benefit from the construction or acquisition project.

(Authority: 38 U.S.C. 8135(b))

(2) Notify the State submitting the application whether the application conforms with such requirements, and, if it does not, notify the State

(i) Of the actions necessary to bring the application into conformance with those requirements; and

(ii) If the application provides insufficient information for the Secretary to establish its priority under subparagraph (1) of this paragraph; and

(3)(i) If such application provides sufficient information for the Secretary to establish its priority, determine the priority of the project described in the application in relation to all other projects in accordance with the criteria set forth in this paragraph. In establishing a project's priority, the Secretary shall rank projects from the highest to the lowest priority in the order of priority groups set forth in this paragraph, giving the projects in Group 1 the highest priority and the projects in Group 6 the lowest. Where more than one project is ranked in a single priority group, the Secretary shall rank those projects by applying the criteria applicable to the next lower priority group. If a State's application for Federal assistance for a project that exceeds 50 percent of the next fiscal year's estimated appropriation for State home grants will be placed at the bottom of the priority group in which it is ranked. Where such ranking results in more than one project being given the same priority, the Secretary shall rank those projects, except as otherwise provided, in accordance with the criteria applicable to the next lowest priority group until all projects are ranked with a different priority.

(ii) The priority groups are:

(A) *Priority Group 1:* A State veterans nursing home or domiciliary project for which a State, in the judgment of the Secretary, has made sufficient funds available for construction and/or acquisition so that the project may proceed upon approval of the grant which the State has requested without further action required by the State to make such funds available for that purpose, shall be accorded first priority. For the purpose of the priority list, the Secretary will accept the following as demonstrating that a State has made sufficient funds available:

(*1*) A copy of the Act, as approved by the Governor, making available at least one-half of the State's matching funds for the project; and

(*2*) A letter from an authorized State budget official certifying that at least one-half of the State funds are, or will be, available for the project, so that if VA approves the grant during the next fiscal year, the project may proceed without further State action to make such funds available.

(B) *Priority Group 2:* A State veterans nursing home or domiciliary project from a State which has not received a construction or acquisition grant from the Secretary under 38 U.S.C. 15035 shall be accorded second priority.

(C) *Priority Group 3:* A State veterans nursing home or domiciliary bed producing or non-bed producing project from a State, which the Secretary determines, pursuant to this paragraph, to have a greater need for State veterans nursing home or domiciliary beds than other States which have submitted applications, shall be accorded third priority. The Secretary shall base such determinations on the Secretary's calculation, pursuant to this paragraph, of the State's unmet need for such beds. A State which has submitted an application for a project which the Secretary determines to be primarily a nursing home project will be deemed to have a greater need for State veterans nursing home beds than other States if the Secretary determines that the State has an unmet need for such beds of between 91 percent and 100 percent. The Secretary shall determine a State's unmet need for State veterans nursing home beds by dividing the number of that State's nursing home beds authorized by the Department of Veterans Affairs in State veterans Homes as of August 15 of the current year by the number of beds needed to provide adequate nursing home care to veterans residing in that State as prescribed by the Secretary in appendix A. The quotient, expressed as a percentage will be subtracted from 100 percent. The difference constitutes the State's unmet need for State veterans nursing home beds for purposes of this section. The Secretary shall determine a State's unmet need for domiciliary beds by dividing the number of that State's domiciliary beds authorized by the Department of Veterans Affairs as of August 15 of the current year by the number of beds needed to provide adequate domiciliary care to veterans residing in that State prescribed by the Secretary in appendix A. The quotient, expressed as a percentage will be subtracted from 100 percent. The difference constitutes the State's unmet need for State veterans domiciliary beds for purposes of this section.

(D) *Priority Group 4:* A State veterans nursing home or domiciliary project, which is not assigned a higher priority under this section, shall be accorded fourth priority. If there is more than one project in this priority group, the Secretary shall assign each project a value as set forth in the following table in accordance with the Secretary's determination of the type of project:

| Type of project | Value |
|---|---|
| Life-safety project for nursing home facility | 10 |
| Project resulting in the construction or acquisition of nursing home beds | 10 |
| Life-safety project for domiciliary facility | 9 |
| Project resulting in the construction or acquisition of domiciliary beds | 8 |
| Nursing home renovation project | 6 |
| Domiciliary renovation project | 4 |

If the Secretary determines that a project could be included in two or more of the above-listed types so that the project, in the judgment of the Secretary, cannot be accurately characterized as to type by reference to any single type listed above, the Secretary shall determine the numerical value to be assigned a project by calculating the average of all the numerical values associated with all types of projects in which the project could be included. The Secretary shall rank projects in accordance with the numerical values assigned, with the highest priority being assigned to the project with the highest numerical valuation. Where this results in two or more projects with the same priority, these projects shall be ranked in the order in which the Secretary received the State's preapplication for that project giving highest priority to the project for which a preapplication was received first. If a preapplication was not received by the Secretary for a project, the project shall be ranked with other projects using the date on which the Secretary received the application for the projects.

(E) *Priority Group 5:* A project which is primarily designed to renovate a State veterans hospital facility but which would not expand a State's capacity to furnish hospital care in a State veterans home shall be accorded fifth priority. Where more than one project is ranked in this priority group, the Secretary shall rank them in the order in which the Secretary received the State's preapplication for the project and shall give highest priority to the project for which a preapplication was received first. If a preapplication was not received by the

Secretary for a project, the project shall be ranked with other projects using the date on which the Secretary received the application for the project.

(F) *Priority Group 6:* A hospital project which would expand a State's capacity to furnish hospital care in a State veterans home shall be accorded no priority. Where more than one such project has been submitted, the Secretary shall rank them in the order in which the Secretary received the State's preapplication for the projects and shall assign the lowest ranking to the project for which a preapplication was received last. If a preapplication was not received by the Secretary for a project, the project shall be ranked with other projects using the date on which the Secretary received the application for the project.

(Authority: 38 U.S.C. 8135(b))

(d) The Secretary shall establish after August 15 of each year a list of projects, including projects that have been conditionally approved under paragraph (e) of this section, in the order of their priority on August 15 of that year as determined pursuant to paragraph (c) of this section. To the extent that Federal funds are available, the Secretary shall award grants in the order of their priority on this list during the fiscal year beginning on October 1 of the calendar year in which the list is made. Once the list is established for the purpose of awarding grants, the Secretary shall not add projects or change the list in any way except to delete a project at the request of the State which has applied for grant assistance for that project or upon the award by the Secretary of a grant for a project on the list.

(Authority: 38 U.S.C. 8135(b)(4))

(e) The Secretary may conditionally approve a project, conditionally award a grant for the project, and obligate funds for the grant if:

(1) The grant application is sufficiently complete to warrant the conditional award; and

(2) The State requests conditional approval for its application and provides the Department of Veterans Affairs written assurance that it will complete the application and meet all requirements not later than 90 days after the date of conditional approval by the Secretary of the Department of Veterans Affairs.

The final grant award shall not exceed 10 percent of the amount conditionally approved, and in no case shall the total amount of the grant exceed 65 percent of the total estimated cost of the project. If the State fails to complete the remaining requirements within the 90 days from the date of conditional approval, the Secretary shall rescind the conditional approval and grant award, and deobligate the funds previously obligated for the project.

(Authority: 38 U.S.C. 8135(b) (4), (6)(A)–(7)(B))

(f)(1) The Secretary shall defer approval of an application that otherwise meets the requirements of 38 U.S.C. 8135, if the State which submitted the application does not, by July 1 of the Federal fiscal year in which the State is notified by the Assistant Chief Medical Director for Geriatrics and Extended Care of the availability of Federal funding for a grant for the project described in the application, demonstrate that the State has provided adequate financial support (matching funds) for such project. A State's enactment into law of a bill appropriating the State's share of funding for the project is acceptable to demonstrate that the State has provided adequate financial support (matching funds) for the project. The Department of Veterans Affairs will evaluate other types of assurances on a case by case basis.

(2) The Secretary will apply Federal funds, which had been intended for an application which has been deferred pursuant to subparagraph (1) of this paragraph to applications for State veterans nursing home or domiciliary projects that:

(i) Would not have been funded during the fiscal year but for the deferral,

(ii) Will meet the requirements of these regulations by the end of the Federal fiscal year, and

(iii) The Secretary has accorded the highest priority under paragraph (c) of this section.

(3) An application deferred in accordance with paragraph (e)(1) of this section shall be accorded priority in any subsequent Federal fiscal year ahead of applications that had not been approved before the first day of the Federal fiscal year in which the deferred application was first approved.

(Authority: 38 U.S.C. 8135(b)(5))

(g) The amount of a grant under these regulations shall be paid to the applicant or, if designated by the applicant, the State home for which such project is being developed or any other agency or instrumentality of the applicant. Funds paid for an approved project will be used solely for carrying out such project as so approved.

(Authority: 38 U.S.C. 8135(d)(1))

(h) Any amendment of any application whether or not approved under paragraph (d) of this section will be subject to review and approval pursuant to the regulations concerning grants to States for construction of State home facilities in the same manner as an original application.

(Authority: 38 U.S.C. 8135(e))

(i) Any amendment of any application whether or not approved under paragraph (c) of this section will be subject to review and approval pursuant to the regulations concerning grants to States for construction of State home facilities in the same manner as an original application.

(Authority: 38 U.S.C. 8135(e))

(Information collection requirements contained in §17.213 were approved by the Office of Management and Budget under control number 2900–0502)

[45 FR 38357, June 9, 1980, as amended at 47 FR 27859, June 28, 1982; 48 FR 1490, Jan. 13, 1983; 52 FR 23826, June 25, 1987; 54 FR 34983, Aug. 23, 1989; 56 FR 20354, May 3, 1991. Redesignated and amended at 61 FR 21966, 21968, May 13, 1996]

### §17.214 Disallowance of a grant application and notice of a right to hearing.

(a) Before disapproving an application submitted under §17.213, the Secretary shall notify the applicant of the opportunity for a hearing. The notice shall state:

(1) That the application's disapproval has been proposed;

(2) The basis for the proposed disapproval;

(3) That a request for a hearing should be received in writing by the Secretary within 40 days from the date of this notice;

(4) That failure of an applicant to request a hearing as provided for by this section or to appear at a hearing for which a date has been set shall be deemed a waiver of the opportunity for a hearing.

(b) If an applicant requests a hearing after the expiration of the 40-day period, the Secretary may accept the request.

(c) An applicant who requests a hearing under the procedures specified by this section shall be notified of the time and place for the hearing. If the time or place set is inconvenient for the applicant, the Secretary may change the time or place for the hearing.

(d) The Secretary shall conduct the hearing. The hearing will be informal. The rules of evidence will not be followed. Witnesses shall testify under oath or affirmation. A record or transcript of the hearing shall be made. The Secretary who conducts the hearing may exclude from consideration irrelevant, immaterial, or unduly repetitious evidence or testimony.

(Authority: 38 U.S.C. 8135(c))

[52 FR 23828, June 25, 1987. Redesignated and amended at 61 FR 21966, 21968, May 13, 1996]

### §17.215 Recapture provisions.

(a) Except as provided in paragraph (b) of this section, if within 20 years after completion of any project with respect to which a grant has been made under the regulations concerning grants to States for construction or acquisition of State home facilities, a facility constructed or acquired as part of such project ceases to be operated by a State, a State home, or an agency or instrumentality of a State principally for furnishing domiciliary, nursing home or hospital care to veterans, the United States shall be entitled to recover from the State which was the recipient of the grant or from the then owner of such construction 65 percent

of the current value of such facility (but in no event an amount greater than the amount of assistance provided for such under these regulations), as determined by agreement of the parties or by action brought in the district court of the United States for the district in which the facility is situated.

(Authority: 38 U.S.C. 8136)

(b) In the case of a grant where the Department of Veterans Affairs would provide between 50 and 65 percent of the estimated cost of expansion, remodeling, or alteration of an existing State Home facility recognized by the Department of Veterans Affairs in accordance with §17.190, the Secretary may at the time of the grant provide for the following recovery periods associated with the following grant amounts.

| Grant amount (dollars in thousands) | Recovery period (in years) |
|---|---|
| 0–250 | 7 |
| 251–500 | 8 |
| 501–750 | 9 |
| 751–1,000 | 10 |
| 1,001–1,250 | 11 |
| 1,251–1,500 | 12 |
| 1,501–1,750 | 13 |
| 1,751–2,000 | 14 |
| 2,001–2,250 | 15 |
| 2,251–2,500 | 16 |
| 2,501–2,750 | 17 |
| 2,751–3,000 | 18 |
| Over 3,000 | 20 |

(Authority: 38 U.S.C. 8136)

If the magnitude of the Department of Veterans Affairs contribution is below 50 percent of the estimated cost of the expansion, remodeling, or alteration of an existing State home facility recognized by the Department of Veterans Affairs in accordance with §17.190, the Secretary may authorize a recovery period between 7 and 20 years depending on the grant amount involved and the magnitude of the project.

[52 FR 23828, June 25, 1987. Redesignated and amended at 61 FR 21966, 21968, May 13, 1996]

### §17.216 General program requirements for construction and acquisition of and equipment for State home facilities.

(a) *Introduction.* (1) The general program requirements set forth in this section have been established to guide the State agencies and their architects in preparing drawings, specifications, cost estimates, and the equipment list for the grant application.

(2) States shall apply the Uniform Federal Accessibility Standards (UFAS) (24 CFR part 40, appendix A), during the design and construction of State home projects. UFAS standards establish requirements for facility accessibility by physically handicapped persons for Federal and Federally-funded facilities and were jointly developed by the General Services Administration, the Department of Housing and Urban Development, the Department of Defense, and the United States Postal Service, under the authority of sections 2, 3, 4, and 4a of the Architectural Barriers Act of 1968, as amended, Public Law 90–480, 42 U.S.C. 4151–4157.

(3) States must comply with these requirements where they exceed any National, State, or local codes. If the State or local codes exceed these general requirements, compliance with the more stringent standard is required.

(4) The space allotted to the various services (i.e., medical, nursing, dietary, and the like) will depend upon the requirements of the facility. Some services that are required by these regulations to be in separate spaces or rooms, may be combined if the result will not compromise safety and medical and nursing practices. The Department of Veterans Affairs shall accept a design and waive minimum requirements where a service or services will have minimal renovations and remain in their present locations.

(Authority: 38 U.S.C. 8134(2))

(b) *General conditions of the contract for construction.* The applicant may use the general conditions of the contract for construction of the American Institute of Architects (AIA) or other general conditions as required by the State in awarding contracts for State home grant projects. (See 37 CFR part 43 for contract requirements.)

(c) *Program criteria.* The State will use the program criteria in §§17.217 and 17.218, as required by the scope of the

project, subject to the approval of the Department of Veterans Affairs.

(Authority: 38 U.S.C. 8134(2))

[56 FR 20355, May 3, 1991. Redesignated and amended at 61 FR 21966, 21968, May 13, 1996]

### § 17.217 Domiciliary and nursing home care program.

(a) *Objective.* Domiciliary and nursing home care facilities should provide a therapeutic, rehabilitative, safe and home-like environment to assist in maintaining or restoring veterans to the highest level of functioning. Long-term care facilities shall be designed to encourage and facilitate participation in therapeutic programs.

(Authority: 38 U.S.C. 8134(2))

(b) *General.* All newly constructed domiciliary beds shall meet nursing home care construction standards and be suitable to provide for future conversion to nursing home care if needed. The Department of Veterans Affairs may waive this requirement if the State shows that it will need domiciliary beds more than nursing home beds for eligible veterans. See § 17.222 of this part.

(Authority: 38 U.S.C. 8134(2))

(c) *Nursing units.* A nursing unit with related facilities will normally be constructed so that nurses may supervise 30 to 60 patients. If there are design limitations, fewer beds are permissible. A 30-bed unit with a centrally located nursing station is preferred on skilled care units to provide efficient use of staff. A design that minimizes the distance between rooms and nursing stations is recommended. Patient storage may be planned in each nursing unit for bulky clothing that will not fit into patients' closets. A nurses' call system shall be required for nursing units. Each patient shall be furnished with an audiovisual or visual nurses' call system which will register a call from the patient with the signal light above the corridor door and at the nursing station in hospitals and nursing homes. An empty conduit system shall be installed for domiciliaries for use in a potential future conversion to a nursing home. A nursing call system shall also be provided in each patient's toilet room and bathroom. Wiring for a nurses' call system shall be installed in conduit.

(Authority: 38 U.S.C. 8134(2))

(d) *Bed configurations.* At least 80 percent of the total beds should be in single and/or double bed rooms. Rooms shall have no more than four beds. Two large two-bed rooms are allowed for a 50–60 bed unit. Adequate space should be provided to allow access to three sides of each bed for the staff to work and utilize medical and emergency equipment.

(Authority: 38 U.S.C. 8134(2))

(e) *Patient bedrooms.* Each bedroom shall have direct access to an enclosed toilet and lavatory. The percentage of the patient bedrooms that shall be accessible to the physically handicapped must comply with UFAS requirements. These rooms must include UFAS clearances around beds and 5-foot wheelchair turning radius. Individual privacy should be provided by screens, privacy curtains, or similar approaches in bedrooms for more than one patient. No patient room shall be located on a floor which is more than 50 percent below grade level. It is desirable that patient rooms include:

(1) Wardrobes with closets and drawers large enough to accommodate the personal clothing of patients who require care for an extended period of time.

(2) Room for a desk, lounge chair, television, and other personal belongings.

(3) Total electric beds.

(4) A sink and mirror.

(5) Piped oxygen and vacuum suction for patients as required.

(6) Operable windows to allow access to air. The sill shall be low enough to permit patients to view the ground while sitting.

(Authority: 38 U.S.C. 8134(2))

(f) *Patient room toilets.* Patient toilets must be designed for maximum accessibility and safety for the patients and to facilitate staff assistance. One toilet/bathroom for each bedroom is preferred with a maximum of four beds for each bathroom. Shower/tub rooms should provide an area for setting clean clothes and supplies. Adequate ventilation should be provided to prevent condensation and mildew. The percentage

of the patient toilets/bathrooms that are accessible to the physically handicapped must comply with UFAS requirements. These rooms must include UFAS clearances, grab bar configurations, and mounting heights. Alternative grab bar configurations may be used for the remaining percentage of patient toilets/bathrooms as approved by the Department of Veterans Affairs.

(Authority: 38 U.S.C. 8134(2))

(g) *Reception and control.* Information, telephone, switchboard, mailboxes, and control center facilities should be located adjacent to the main lobby entrance. The information desk serves as a first point of contract, information, and control area for those entering for admission, a visit, or business.

(Authority: 38 U.S.C. 8134(2))

(h) *Administrator/Director's suite.* The project may include an administrator/director's suite to include all administrative activities required by the Director, Assistant Director, and their immediate staffs, including secretaries, analysts, administrative assistants, and/or trainees.

(Authority: 38 U.S.C. 8134(2))

(i) *Dietetic Service.* Dietetic Service facilities such as an office for the dietitian, a kitchen, a dishwashing room, adequate refrigeration, dry storage, receiving area, and garbage facilities should be provided as required. It is desirable to have eating areas on each unit that have a sink, toilet facilities, and storage, that can accommodate wheelchairs and gerichairs, while still being attractive and appealing for dining. Tables should be able to accommodate three to four wheelchairs. Buffet lines may be provided on the unit to allow some choice for patients who cannot get to the main dining room.

(1) Dining room, food preparation, and dishwashing facilities may be planned as separate facilities from Dietetic Service area, if appropriate.

(2) Space for vending machines may be provided.

(Authority: 38 U.S.C. 8134(2))

(j) *Therapy and treatment programs.* Facilities for rehabilitation medicine, physical, occupational, and recreational therapies and other programs shall be planned by the State to meet program requirements and standards of care prescribed by the Department of Veterans Affairs. In addition to the patient therapy spaces, offices may be provided. Medical support areas should be planned to meet program requirements and standards and may include areas for rehabilitation, recreation, dental care and other medical support services.

Authority: 38 U.S.C. 8134(2))

(k) *Janitors closet.* One janitors closet should be planned for each nursing unit, in the dietetic area, and in the general administrative and clinical space with at least one on each floor. The kitchen and other areas which generate waste or require special care should have their own janitors closet. Convenient storage for floor cleaning machines may also be provided.

(Authority: 38 U.S.C. 8134(2))

(l) *Staff facilities.* Staff toilets should be provided on each floor. Each facility should have an employee locker and lounge.

(Authority: 38 U.S.C. 8134(2))

(m) *Conference room/In-service training.* A conference room which may also be used for staff training and development may be provided. Family and group counseling rooms may also be provided.

(Authority: 38 U.S.C. 8134(2))

(n) *Lounges/recreation.* Two patient lounges which will accommodate large numbers of wheelchair/gerichairs should be considered. Lounges may be separated, one for smokers and one for non-smokers. Lounges should be directly visible from the nursing station or adjacent to the nursing station. Atriums may be planned on the nursing unit, or provisions may be made for access to an outdoor sundeck or patio. An outdoor recreation/patio space should be developed adjacent to a common use area. Every effort should be made to reduce the noise levels on the nursing unit by using noise reducing materials in construction and decorating.

(Authority: 38 U.S.C. 8134(2))

(o) *Miscellaneous space.* The State home may include space for a library, barber and/or beauty shop, retail sales, canteen, mailroom, chapel, and computer communications area. Space for a child day care center may be planned if it will primarily serve the needs of persons employed by the State home. Whirlpools and wheelchair scales may be provided for each State home built to nursing home standards. Other spaces in the State home must be fully justified by the applicant and approved by the Department of Veterans Affairs before the Department of Veterans Affairs can participate in funding the cost of the area.

(Authority: 38 U.S.C. 8134(a))

[56 FR 20355, May 3, 1991. Redesignated and amended at 61 FR 21966, 21968, May 13, 1996]

### § 17.218 State home hospital program.

(a) *General.* The Department of Veterans Affairs cannot participate in the construction of new State home hospitals. However, the Department of Veterans Affairs may participate in the remodeling, alteration, or expansion of existing State home hospitals.

(Authority: 38 U.S.C. 8134(2))

(b) *Hospital's nursing units.* Patient bedrooms may be grouped into distinct nursing units for general medical and surgical patients, and psychiatric patients. A 40-bed unit is most desirable; however, a range of 30–50 beds may be considered.

(Authority: 38 U.S.C. 8134(2))

(c) *Distribution of beds.* Single-bed rooms should be provided for patients who are infectious, terminal, or who for other reasons require separation.

(Authority: 38 U.S.C. 8134(2))

(d) *Construction requirements.* A State may use its own construction standards for a State hospital alteration or expansion if the plans are approved by the State's Department of Health and the State agency responsible for the State home hospital. The grantee should follow applicable National, State, and/or local codes for hospital construction, remodeling, and/or renovation.

(Authority: 38 U.S.C. 8134(2))

(Information collection requirements contained in § 17.218 were approved by the Office of Management and Budget under control number 2900–0520)

[56 FR 20356, May 3, 1991. Redesignated at 61 FR 21966, May 13, 1996]

### § 17.219 Preapplication phase.

A State shall submit to the Department of Veterans Affairs a preapplication (SF–424, 424C, and 424D) for Federal assistance for each State home project if Federal participation exceeds $100,000. An original and two copies are required. Costs incurred for the project by the State after the date the Department of Veterans Affairs notifies the State that the project is feasible for Department of Veterans Affairs participation are allowable costs if the application is approved and the grant is awarded. These pre-award expenditures include architectural and engineering fees.

(Authority: 38 U.S.C. 8134(2))

(a) *Purpose.* A preapplication is required to determine the applicant's general eligibility, to establish communication between the Federal agency and the applicant, and to identify those proposals which are not feasible for Department of Veterans Affairs participation before the applicant incurs significant expenditures in preparing a formal application. Filing a preapplication by April 15 of each year will give the Department sufficient time to accomplish these purposes. The State shall submit to the Department of Veterans Affairs a letter designating the State Official authorized to apply for a State home construction or acquisition grant and a point of contact for all matters relating to a State home grant. If the authorized State official is changed, notice shall be provided in writing to the Department of Veterans Affairs.

(Authority: 38 U.S.C. 8134(2))

(b) *Preapplication requirements.* The preapplication shall include schematic drawings, a space program, and a needs assessment. States applying for Federal assistance for new State home

beds shall provide justification for the beds by addressing the following areas:

(1) Demographic characteristics of the veteran population of the area;

(2) Availability and suitability of alternative health care providers and facilities in the area;

(3) Waiting lists for existing State home beds;

(4) Documentation that existing State home facilities in the State meet current codes and standards;

(5) Availability of acute medical care services and qualified medical care personnel to staff the proposed facility;

(6) Other information that may be required by the Assistant Chief Medical Director for Geriatrics and Extended Care in the Department of Veterans Affairs.

(Authority: 38 U.S.C. 8134(2))

(c) *Revisions to preapplications.* Grantees shall request approval from the Department of Veterans Affairs for significant revisions after preapplications have been submitted to the Department of Veterans Affairs. If the scope changes and/or cost estimates increase by more than 10 percent, a new preapplication may be required which will be subject to the same review and approval procedure as for the original preapplication.

(Authority: 38 U.S.C. 8134(2))

(Information collection requirements contained in §17.219 were approved by the Office of Management and Budget under control number 2900–0520)

[56 FR 20357, May 3, 1991. Redesignated at 61 FR 21966, May 13, 1996]

### §17.220 Application phase.

(a) *General.* The applicant shall submit an original and two copies of the formal application (SF 424, 424C, and 424D) after the preapplication has been reviewed by the Department of Veterans Affairs and determined feasible for Department of Veterans Affairs participation. The application must meet the requirements of parts 43 and 44 of this chapter and include an updated space program, design development plans (35 percent), and specifications as outlined in paragraph (b) of this section.

(Authority: 38 U.S.C. 8134(2))

(b) *VA review.* (1) *Program.* The applicant shall provide a narrative description of existing or planned program(s) at the facility and how this project will affect the operation of the existing State home (if applicable).

(2) *Cultural resources.* The applicant shall provide a letter and two copies from the State Historic Preservation Officer (SHPO) stating whether the project area includes any properties on, eligible for, or likely to meet the criteria for the National Register of Historic Places. If the property does, or may include, National Register quality properties, the letter from the SHPO should discuss the determination of effect of the proposed project on such property.

(3) *Design development site plan.* The applicant shall submit a site survey which has been performed by a licensed land surveyor. A description of the site shall be submitted noting the general characteristics of the site. This should include soil reports and specifications, easements, main roadway approaches, surrounding land uses, availability of electricity, water and sewer lines, and orientation. The description should also include a map locating the existing and/or new buildings, major roads, and public services in the geographic area. Additional site plans should show all site work including property lines, existing and new topography, building locations, utility data, and proposed grades, roads, parking areas, walks, landscaping, and site amenities.

(4) *Design development (35 percent) drawings.* The applicant shall provide to the Department of Veterans Affairs one set of sepias and eight sets of prints, rolled individually per set, to expedite the review process. The drawings shall indicate the designation of all spaces, size of areas and rooms and indicate in outline the fixed and movable equipment and furniture. The drawings shall be drawn at ⅛″ or ¼″ scale. Bedroom and toilet layouts, showing clearances and UFAS requirements, should be shown ¼″ scale. The total floor and room areas shall be shown in the drawings. The drawings shall include:

(i) Plan of any proposed demolition work;

(ii) A plan of each floor. For renovations, the existing conditions and extent of new work should be clearly delineated;

(iii) Elevations;

(iv) Sections and typical details;

(v) Roof plan;

(vi) Fire protection plans; and

(vii) Technical engineering plans, including structural, mechanical, plumbing, and electrical drawings.

If the project involves acquisition, remodeling, or renovation, the applicant should include the current as-built site plan, floor plans and building sections which show the present status of the building and a description of the building's current use and type of construction.

(5) *Space program.* The State shall submit a space program which includes a list of each room or area and the square feet proposed. The plan should note special or unusual services or equipment. The format should be similar to the Chart of Net Square Feet Allowed and room titles contained in §17.222 (c)(5)(i) through (c)(5)(iii) of this part.

(6) *Design development outline specifications.* The applicant shall provide eight copies of outline specifications which shall include a general description of the project, site, architectural, structural, electrical, and mechanical systems such as elevators, nurses' call system, air conditioning, heating, plumbing, lighting, power, and interior finishes (floor coverings, acoustical material, and wall and ceiling finishes).

(7) *Design development cost estimates.* Three copies of cost estimates shall be included in the application to the Department of Veterans Affairs. Estimates shall show the estimated cost of the buildings or structures to be acquired or constructed in the project. Cost estimates should list the cost of construction, contract contingency, fixed equipment not included in the contract, movable equipment, architect's fees, and construction supervision and inspection. Unless justified by the State, the Department of Veterans Affairs allowance for equipment not included in the construction contract shall not exceed 10 percent of the construction or acquisition contract cost. The Department of Veterans Affairs allowance for contingencies shall not exceed 5 percent of the total project cost for new construction or 8 percent of the total project cost for remodeling or renovation projects. If the project involves non-Federal participating areas, such costs should be itemized separately.

(8) *Design development conference.* After Department of Veterans Affairs review of the design development documents, a design development conference is recommended for all major projects. This will provide an opportunity for the applicants and their architects to learn Department of Veterans Affairs procedures and requirements for the project and to discuss Department of Veterans Affairs review comments. The material in paragraphs (b)(1) through (b)(7) of this section should be submitted for Department of Veterans Affairs review at least three weeks before the design development conference in the Department of Veterans Affairs Central Office in Washington, DC.

(Authority: 38 U.S.C. 8134(2))

(c) *Final review and approval (100% construction documents, bid tabulations and cost estimates).* (1) The applicant shall submit to the Department of Veterans Affairs for review and approval one labeled set of microfiche aperture cards, microfilm, or Compact Disc/Read Only Memory (CD ROM) compact laser disc with 100% construction documents (plans and specifications). The applicant shall also submit three copies of: itemized bid tabulations; assurances of compliance with Federal requirements, and revised budget page (SF 424C) based on the selected bids. This should include final cost estimates for all item in the project. Three signed copies of the Memorandum of Agreement shall be submitted which reflect the total estimated cost of the project and the Department of Veterans Affairs participation in the total cost.

(2) Following approval of final construction documents, bid tabulations, and costs estimates, the Secretary will sign the Memorandum of Agreement

awarding the grant and committing available Federal funds.

(Authority: 38 U.S.C. 8134(2))

(d) *Construction or acquisition.* The State shall enter into a construction or acquisition contract and begin construction or acquisition of the State home within 90 days after the final grant has been awarded by the Secretary of Veterans Affairs. Any delays beyond 90 days must be fully justified by the State and approved by the Department of Veterans Affairs or the grant may be rescinded.

(Authority: 38 U.S.C. 8134(2))

(e) *Grant revisions.* When significant deviations occur in the approved program or budget, the procedures set forth in paragraphs (e) (1) and (2) of this section shall apply.

(1) If a State has received the award of a construction or acquisition grant, the State shall request prior approval from the Department of Veterans Affairs for programmatic or budgetary revisions when the scope or objective of the project changes in a significant manner or when an approved line item budgeted amount increases or decreases by more than 10 percent. All grant modifications of this type shall be within the total contingency allowance of 5 percent for new construction or 8 percent for remodeling or renovation.

(2) In unusual and unanticipated circumstances, the Department of Veterans Affairs may participate in modifications to a grant that exceeds the contingency allowance by awarding a grant increase for the project. A grant increase will require an amended application from the State and complete justification, subject to the approval of the Department of Veterans Affairs. The amended application for a grant increase will be treated as an original application for the purpose of the priority list and the award of any additional Federal funds for the project.

(Authority: 38 U.S.C. 8135(e))

(f) *Final architectural and engineering inspection.* The grantee shall notify the Department of Veterans Affairs immediately upon completion of the project and request a final architectural and engineering inspection. This inspection is required prior to final payment under the construction or acquisition grant.

(Authority: 38 U.S.C. 8134(2))

(Information collection requirements contained in §17.220 were approved by the Office of Management and Budget under control number 2900–0520)

[56 FR 20357, May 3, 1991. Redesignated and amended at 61 FR 21966, 21968, May 13, 1996]

### § 17.221 Equipment.

(a) *General.* Equipment necessary for the State home's planned effective operation shall be included in the cost of the project.

(Authority: 38 U.S.C. 8134(2))

(b) *Definition of equipment.* The term *equipment* as used in this section means all items necessary for the functioning of all services of the State home, including equipment as needed to provide for accounting and other records, and maintenance of buildings and grounds. The term *equipment* does not include consumable supplies such as food, drugs, dressings paper, printed forms, soap, and the like which are routinely required to operate the State home.

(Authority: 38 U.S.C. 8134(2))

(c) *Classification of equipment.* All equipment shall be classified in two groups as indicated in paragraphs (c) (1) and (2) of this section:

(1) *Fixed equipment (included in construction/acquisition contract).* Fixed equipment is permanently affixed to the building or is connected to service distribution systems designed and installed during construction (e.g., kitchen and intercommunication equipment, built-in casework, and cubicle curtain rods). The Federal share in the cost of such equipment, included in the construction contract, will be determined by the Department of Veterans Affairs percentage of participation in the aggregate cost of the project.

(2) *Movable and fixed equipment (not included in project contact).* Movable and fixed equipment may be purchased separately from the construction or acquisition contract and includes furniture, furnishings, wheeled equipment, kitchen utensils linens, draperies, venetian blinds, electric clocks, pictures and trash cans. The Federal share in the

cost of such equipment not included in the project contract will be limited to 10 percent of the project contract cost unless justified by the State and approved by the Department of Veterans Affairs.

(Authority: 38 U.S.C. 8134(2))

(d) *Purchase of equipment.* (1) The State shall select and purchase all equipment for the complete and effective functioning of services needed to operate the State home. The State may postpone purchasing of equipment until the facility is almost ready for occupancy to assure that the most current models of equipment are purchased. The equipment shall meet State standards. Title to all equipment purchased by the State with grant monies shall be vested to the State.

(2) The quality and amount of equipment shall be properly apportioned to the various services of the facility so that unduly expensive or elaborate equipment is not provided for some services at the expense of other services.

(Authority: 38 U.S.C. 8134(2))

(e) *Equipment list.* (1) Prior to the completion of the project, the State shall submit to the Department of Veterans Affairs for approval a separate, complete itemized list of fixed and movable equipment, not included in the construction contract. Fixed equipment shall be itemized by category of equipment with the estimated cost of each category or item and the total cost. Movable equipment shall be itemized according to the rooms or functional areas identified on the final drawings. The list shall show the quantity and estimated cost of each item. The quantity will be based on the actual number of units and number of beds in each unit.

(2) The Department of Veterans Affairs will review the equipment list to ascertain medical applicability, quantity, and cost of items. The quantity will be determined by the number of nursing or domiciliary units, the number of bed areas provided, and the items required to make constructed or acquired areas functional. Medical applicability will be determined by whether such items are normally found or used in the type of medical activity/area planned. The Department of Veterans Affairs may disapprove items on the equipment list, but the applicant will be given the opportunity to justify such item(s).

(Authority: 38 U.S.C. 8134(2))

(Information collection requirements contained in § 17.221 were approved by the Office of Management and Budget under control number 2900–0520)

[56 FR 20358, May 3, 1991. Redesignated at 61 FR 21966, May 13, 1996]

### § 17.222 General design guidelines and standards.

(a) *General.* Nursing homes and domiciliaries should be planned to approximate the home atmosphere as closely as possible. These guidelines and standards include minimum requirements for site selection and development; architectural design including handicapped accessibility and allowable space criteria; structural, mechanical, and electrical design; plumbing systems and elevator requirements; fire safety criteria; and asbestos abatement rules. State homes to be constructed or acquired with Federal financial assistance shall comply with applicable National, State, and local codes. Such codes include building codes, electrical codes, seismic codes, fire and life safety codes, plumbing codes, and others. Both nursing homes and domiciliaries are health care occupancies, and all space shall be protected with a sprinkler system as well as quick response sprinklers for all smoke compartments containing patient sleeping rooms.

(1) Except as provided in paragraphs (a)(1)(i) and (a)(1)(ii) of this section, in no case shall the total cost of remodeling exceed the cost of constructing a comparable new building or facility.

(i) If a building or facility is on or eligible for the National Register of Historic Places, the total cost of remodeling, renovating, or adapting it may exceed the cost of comparable new construction by five percent.

(ii) If the demolition of a building on or eligible for the National Register of Historic Places is necessary, the cost to professionally record the building for the Historic American Buildings Survey (HABS) plus the total cost for demolition and site restoration shall be

included by the State in calculating the total cost of new construction.

(2) The cost of routine maintenance and replacement of mechanical, electrical, structural and architectural work, or maintenance and repair of any building system or equipment will not be considered as a cost for construction or acquisition for a State home grant application. The Department of Veterans Affairs may waive this requirement if it is determined that the work is necessary to comply with standards of life safety or quality patient care or is involved inextricably with the construction or acquisition project.

(b) *Site selection and development.*—(1) *Site accessibility.* The site should be located in a safe, secure, residential-type area which is accessible to acute medical care facilities, community activities and amenities, and transportation facilities typical of the area.

(2) *Mineral rights.* The State shall establish whether the site is subject to mineral rights which have not been developed and include a report on the mineral rights as part of the formal application.

(3) *Limitations.* The State should avoid sites that are near insect-breeding areas, noise or other industrial developments: airports, railways or highways producing noise or air pollution; or potential flood hazards. In the event that these site related disadvantages cannot be avoided, adequate provision will be made to eliminate or minimize the condition.

(4) *Alternatives.* The State shall look at alternative sites for the State home unit and submit a report on these sites to the Department of Veterans Affairs for review early in the application phase.

(5) *Demolition plan.* The cost of demolition of a building cannot be included in the cost of construction unless the proposed construction is in the same location as the building to be demolished or unless the demolition is inextricably linked to the design of the construction project. If the State believes that this cost may be included in the cost of the construction project, a demolition plan should be submitted which includes the extent and cost of existing site features to be removed, stored, or relocated.

(6) *Asbestos abatement.* For existing buildings, a certified industrial hygienist shall be hired for assessment, design, cost estimate, and construction monitoring for asbestos abatement. The abatement process shall follow EPA, OSHA, State, and local regulations and guidelines.

(c) *Architectural requirements.* (1) *Finishes.* Walls shall be washable or easily cleaned and smooth. Walls in kitchens and related spaces shall have glazed materials or similar finish and bases shall be waterproof and free from voids. Walls subjected to wetting should also be glazed to a point above the splash or spray line. Wainscots of durable material should be used in patient corridors and other corridors where there is considerable wheeled traffic. Emphasis should be placed on the use of materials for walls and floors that are safe, sanitary, and noise-reducing. The color scheme should provide an attractive and therapeutic environment for elderly patients.

(2) *Handicapped accessibility.* All State home facilities shall provide necessary ingress, egress, and movement throughout the facility for the physically handicapped and elderly in compliance with the Uniform Federal Accessibility Standards (UFAS). Disabled persons shall be provided with access and use that is independent, convenient, and substantially equivalent to that provided other persons.

(3) *Doors.* All doors should be easy to open and in accordance with UFAS requirements.

(4) *Fire Protection.* Facilities shall meet the applicable provisions of the 1988 edition of the National Fire Protection Association's Life Safety Code, NFPA 101, dated February 2, 1988, including NFPA 101M, Alternative Approaches to Life Safety, dated December 2, 1987, (which are incorporated by reference). Incorporation by reference of the 1988 edition of the Life Safety Code including NFPA 101M was approved by the Director of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. The Code is available for inspection at the Office of the Federal Register, room 8301, 800 North Capitol Street, NW., suite 700,

Washington, DC. Copies may be obtained from the National Fire Protection Association, Battery March Park, Quincy, MA 02269. If any changes in this Code are also to be incorporated by reference, a document to that effect will be published in the FEDERAL REGISTER.

(5) *Space program criteria.* (i) *General.* The chart at paragraph (c)(5)(iii) of this section shows the net square footage allowed for Department of Veterans Affairs participation in the cost of the State nursing homes and domiciliaries.

(ii) *Deviations.* Any deviation from these space criteria of more or less than 10 percent, except to meet a more stringent State or local requirement, must be justified by the State and approved by the Department of Veterans Affairs if the space is to be included in the cost of construction. The Assistant Chief Medical Director for the Office of Geriatrics and Extended Care may approve a deviation if it will improve the safety, quality of care, or quality of life provided to veterans in a State home. If a deviation is not approved by the Department of Veterans Affairs, the cost of questionable space will not be included and the percentage of Federal participation may be reduced.

(iii) *Chart of net square feet (NSF) allowed.*

| | Non-Convertible Domiciliary (DOM) | Convertible DOM/Nursing Home |
|---|---|---|
| I. Support facilities (maximum allowable square feet per facility for VA participation): | | |
| Administrator's office | 200 | 200. |
| Assistant administrator | 150 | 150. |
| Medical officer, director of nursing or equivalent | 150 | 150. |
| Nurse's office and dictation area | 120 | 120. |
| General administration (each office/person) | 120 | 120. |
| Clerical staff (each) | 80 | 80. |
| Computer area | 40 | 40. |
| Conference room (consultation area, in-service training) | 300 (each) | 500 (each). |
| Lobby/waiting area | 3 (per bed) (150 min./600 max. per facility). | 3 (per bed). |
| Public/patient toilets (male/female) | 25 (per fixture) | 25 (per fixture). |
| Pharmacy | 0 | (As required). |
| Dietetic service | (As required) | (As required). |
| Dining area | 20 (per bed) | 20 (per bed). |
| Canteen/retail sales | 2 (per bed) | 2 (per bed). |
| Vending machines | 1 (per bed) (450 maximum per facility). | 1 (per bed). |
| Resident toilets (male/female) | 25 (per fixture) | 25 (per fixture). |
| Child daycare | (As required) | (As required). |
| Medical support (staff offices/exam/treatment room/family counseling, etc.). | 140 (each) | 140 (each). |
| Barber and/or beauty shops | 140 | 140. |
| Mail room | 120 | 120. |
| Janitor's closet | 40 | 40. |
| Multipurpose room | 15 (per bed) | 15 (per bed). |
| Employee lockers | 6 (per employee) | 6 (per employee). |
| Employee lounge | 120 (maximum 500 per facility) | 120. |
| Employee toilets | 25 (per fixture) | 25 (per fixture). |
| Chapel | 450 | 450. |
| Physical therapy | 2.5 (per bed) | 5 (per bed). |
| Office if required | 120 | 120. |
| Occupational therapy | 5 (per bed) | 5 (per bed). |
| Office if required | 120 | 120. |
| Library | 1.5 (per bed) | 1.5 (per bed). |
| Building maintenance storage | 2.5 (per bed) | 2.5 (per bed). |
| Resident storage | 6 (per bed) | 6 (per bed). |
| General warehouse storage | 6 (per bed) | 6 (per bed). |
| Medical/dietary | 7 (per bed) | 7 (per bed). |
| General laundry | (As required) | (As required). |
| II. Bed units (50 Beds): | | |
| One | 150 | 150. |
| Two | 230 | 245. |
| Large two-bed (2 per unit) | 0 | 305. |
| Three | 340 | 370 |
| Four | 450 | 460 |
| Lounge areas (resident lounge with storage) | 8 (per bed) | 8 (per bed). |
| Resident quiet room | 3 (per bed) | 3 (per bed). |
| Clean utility | 120 | 120. |

| | Non-Convertible Domiciliary (DOM) | Convertible DOM/Nursing Home |
|---|---|---|
| Soiled utility | 105 | 105. |
| Linen storage | 90 | 150. |
| General storage | 100 | 100. |
| Nurses station, ward secretary | 0 | 260. |
| Medication room | 0 | 75. |
| Waiting area | 50 | 50. |
| Unit supply and equipment | 50 | 50. |
| Staff toilet | 25 (per fixture) | 25 (per fixture). |
| Stretcher/wheelchair storage | 75 | 100. |
| Kitchenette | 150 | 120. |
| Janitor's closet | 40 | 40. |
| Resident laundry | 125 | 125. |
| Trash collection | 60 | 60. |
| III. Bathing and Toilet Facilities:[1] | | |
| (A) Private or shared facilities: | | |
| Wheelchair facilities | 25 (per fixture) | 25 (per fixture). |
| Standard facilities | 15 (per fixture) | 15 (per fixture). |
| (B) Full bathroom | 75 | 75. |
| (C) Congregate bathing facilities: | | |
| First tub/shower | 80 | 80. |
| Each additional fixture | 25 | 25. |

[1] Bathing and toilet facilities must comply with the Uniform Federal Accessibility Standards.

[56 FR 20359, May 3, 1991. Redesignated at 61 FR 21966, May 13, 1996]

## SHARING OF MEDICAL FACILITIES, EQUIPMENT, AND INFORMATION

### § 17.230 Contingency backup to the Department of Defense.

(a) *Priority care to active duty personnel.* The Secretary, during and/or immediately following a period of war or national emergency declared by the Congress or the President that involves the use of United States Armed Forces in armed conflict, is authorized to furnish hospital care, nursing home care, and medical services to members of the Armed Forces on active duty. The Secretary may give higher priority in the furnishing of such care and services in VA facilities to members of the Armed Forces on active duty than to any other group of persons eligible for such care and services with the exception of veterans with service-connected disabilities.

(Authority: 38 U.S.C. 8111A, Pub. L. 97–174)

(b) *Contract authority.* During a period in which the Secretary is authorized to furnish care and services to members of the Armed Forces under paragraph (a) of this section, the Secretary, to the extent authorized by the President and subject to the availability of appropriations or reimbursements, may authorize VA facilities to enter into contracts with private facilities for the provision during such period of hospital care and medical services for certain veterans. These veterans include only those who are receiving hospital care under 38 U.S.C. 1710 or, in emergencies, for those who are eligible for treatment under that section, or who are receiving care under 38 U.S.C. 1712 (f) and (g). This authorization pertains only to circumstances in which VA facilities are not capable of furnishing or continuing to furnish the care or services required because of the furnishing of care and services to members of the Armed Forces.

(Authority: 38 U.S.C. 8111A)

(Authority: Sec. 501 and 1720(a) of Title 38, U.S.C.)

[49 FR 5617, Feb. 14, 1984. Redesignated at 61 FR 21966, May 13, 1996]

### § 17.240 Sharing specialized medical resources.

Subject to such terms and conditions as the Under Secretary for Health shall prescribe, agreements may be entered into for sharing medical resources with other hospitals, including State or local, public or private hospitals or other medical installations having hospital facilities or organ banks, blood banks, or similar institutions, or medical schools or clinics in a medical community with geographical limitations determined by the Under Secretary for Health, provided:

(a) The agreement will achieve one of the following purposes: (1) It will secure the use of a specialized medical resource which otherwise might not be feasibly available by providing for the mutual use or exchange of use of specialized medical resources when such an agreement will obviate the need for a similar resource to be installed or provided at a facility operated by the Department of Veterans Affairs, or

(2) It will secure effective use of Department of Veterans Affairs specialized medical resources by providing for the mutual use, or exchange of use, of specialized medical resources in a facility operated by the Department of Veterans Affairs, which have been justified on the basis of veterans' care, but which are not utilized to their maximum effective capacity; and

(b) The agreement is determined to be in the best interest of the prevailing standards of the Department of Veterans Affairs Medical Program; and

(c) The agreement provides for reciprocal reimbursement based on a charge which covers the full cost of the use of specialized medical resources, incidental hospital care or other needed services, supplies used, and normal depreciation and amortization costs of equipment.

(d) Reimbursement for medical care rendered to an individual who is entitled to hospital or medical services (Medicare) under subchapter XVIII of chapter 7 of title 42 U.S.C., and who has no entitlement to medical care from the Department of Veterans Affairs, will be made to such facility, or if the contract or agreement so provides, to the community health care facility which is party to the agreement, in accordance with:

(1) Rates prescribed by the Secretary of Health and Human Services, after consultation with the Secretary of Veterans Affairs, and

(2) Procedures jointly prescribed by the Secretary of Health and Human Services and the Secretary of Veterans Affairs to assure reasonable quality of care and service and efficient and economical utilization of resources.

(Authority: 38 U.S.C. 8153)

[32 FR 6841, May 4, 1967, as amended at 35 FR 18198, Nov. 28, 1970; 39 FR 1846, Jan. 15, 1974; 45 FR 6940, Jan. 31, 1980; 47 FR 58250, Dec. 30, 1982; 54 FR 34983, Aug. 23, 1989. Redesignated at 61 FR 21966, May 13, 1996, as amended at 62 FR 17072, Apr. 9, 1997]

### § 17.241 Sharing medical information services.

(a) *Agreements for exchange of information.* Subject to such terms and conditions as the Under Secretary for Health shall prescribe, Directors of Department of Veterans Affairs medical centers, may enter into agreements with medical schools, Federal, State or local, public or private hospitals, research centers, and individual members of the medical profession, under which medical information and techniques will be freely exchanged and the medical information services of all parties to the agreement will be available for use by any party to the agreement under conditions specified in the agreement.

(b) *Purpose of sharing agreements.* Agreements for the exchange of information shall be used to the maximum extent practicable to create at each Department of Veterans Affairs medical center which has entered into such an agreement, an environment of academic medicine which will help the hospital attract and retain highly trained and qualified members of the medical profession.

(c) *Use of electronic equipment.* Recent developments in electronic equipment shall be utilized under information sharing programs to provide a close educational, scientific, and professional link between Department of Veterans Affairs medical centers and major medical centers.

(d) *Furnishing information services on a fee basis.* The educational facilities and programs established at Department of Veterans Affairs Medical Centers and the electronic link to medical centers

shall be made available for use by medical entities in the surrounding medical community which have not entered into sharing agreements with the Department of Veterans Affairs, in order to bring about utilization of all medical information in the surrounding medical community, particularly in remote areas, and to foster and encourage the widest possible cooperation and consultation among all members of the medical profession in the surrounding medical community.

(e) *Establishing fees for information services.* Subject to such terms and conditions as the Under Secretary for Health shall prescribe, Directors of Department of Veterans Affairs medical centers shall charge for information and educational facilities and services made available under paragraph (d) of this section. The fee may be on an annual or other periodic basis, at rates determined, after appropriate study, to be fair and equitable. The financial status of any user of such services shall be taken into consideration in establishing the amount of the fee to be paid.

[32 FR 6841, May 4, 1967, as amended at 47 FR 58250, Dec. 30, 1982. Redesignated at 61 FR 21966, May 13, 1996, as amended at 62 FR 17072, Apr. 9, 1997]

### § 17.242 Coordination of programs with Department of Health and Human Services.

Programs for sharing specialized medical resources or medical information services shall be coordinated to a maximum extent practicable, with programs carried out under part F, title XVI of the Public Health Service Act under the jurisdiction of the Department of Health and Human Services.

[32 FR 6842, May 4, 1967, as amended at 45 FR 6940, Jan. 31, 1980; 47 FR 58250, Dec. 30, 1982. Redesignated at 61 FR 21966, May 13, 1996]

GRANTS FOR EXCHANGE OF INFORMATION

### § 17.250 Scope of the grant program.

The provisions of §17.250 through §17.266 are applicable to grants under 38 U.S.C. 8155 for programs for the exchange of medical information. The purpose of these grants is to assist medical schools, hospitals, and research centers in planning and carrying out agreements for the exchange of medical information, techniques, and information services. The grant funds may be used for the employment of personnel, the construction of facilities, the purchasing of equipment, research, training or demonstration activities when necessary to implement exchange of information agreements.

[33 FR 6011, Apr. 19, 1968. Redesignated and amended at 61 FR 21966, 21968, May 13, 1996]

### § 17.251 The Subcommittee on Academic Affairs.

There is established within the Special Medical Advisory Group authorized under the provisions of 38 U.S.C. 7312 a Subcommittee on Academic Affairs, and the Subcommittee shall advise the Secretary, through the Under Secretary for Health, in matters pertinent to achieving the objectives of programs for exchange of medical information. The Subcommittee shall review each application for a grant and prepare a written report setting forth recommendations as to the final action to be taken on the application.

[42 FR 54804, Oct. 11, 1977. Redesignated at 61 FR 21966, May 13, 1996, as amended at 62 FR 17072, Apr. 9, 1997]

### § 17.252 Ex officio member of subcommittee.

The Assistant Chief Medical Director for Academic Affairs shall be an ex officio member of the Subcommittee on Academic Affairs.

[42 FR 54804, Oct. 11, 1977. Redesignated at 61 FR 21966, May 13, 1996]

### § 17.253 Applicants for grants.

Applicants for grants generally will be persons authorized to represent a medical school, hospital, or research center which has in effect or has tentatively approved an agreement with the Department of Veterans Affairs to exchange medical information.

[33 FR 6011, Apr. 19, 1968. Redesignated at 61 FR 21966, May 13, 1996]

### § 17.254 Applications.

Each application for a grant shall be submitted to the Under Secretary for Health on such forms as shall be prescribed and shall include the following

evidence, assurances, and supporting documents:

(a) *To specify amount.* Each application shall show the amount of the grant requested, and if the grant is to be for more than one objective, the amounts allocated to each objective (e.g., to training, demonstrations, or construction) shall be specified, and

(b) *To include copy of agreement.* Each application shall be accompanied by a copy of the agreement for the exchange of information or information services which the grant funds applied for will implement, and

(c) *To include descriptions and plans.* Each application shall include a description of the use to which the grant funds will be applied in sufficient detail to show need, purpose, and justifications, and shall be illustrated by financial and budgetary data, and

(d) *To include cost participation information.* Each application shall show the amount of the grant requested to be used for direct expenses by category of direct expenses, the amount requested for indirect expenses related to the direct expenses, any additional amounts which will be applied to the program or planning from other Federal agencies, and from other sources, and amounts or expenses which will be borne by the applicant, and

(e) *To include assurance records will be kept.* Each application shall include sufficient assurances that the applicant shall keep records which fully disclose the amount and disposition of the proceeds of the grant, the total cost of the project or undertaking in connection with which the grant is made or used, the portion of the costs supplied by non-Federal sources, and such other records as will facilitate an effective audit. All such records shall be retained by the applicant (grantee) for a period of 3 years after the submission of the final expenditure report, or if litigation, claim or audit is started before the expiration of the 3-year period, the records shall be retained until all litigation, claims or audit findings involving the records have been resolved, and

(f) *To include assurance records will be made available.* Each application shall include sufficient assurances the applicant will give the Secretary and the Comptroller General of the United States, or any of their authorized representatives, access to its books, documents, papers, and records which are pertinent to the grant for the purposes of audit and examination, and

(g) *To include assurance progress reports will be made.* Each application shall include sufficient assurances the applicant will furnish the Under Secretary for Health periodic progress reports in sufficient detail showing the status of the project, planning, program, or system funded by the grant for which application is made, and the extent to which the stated objectives will have been achieved, and

(h) *To include civil rights assurances.* Each application shall include sufficient assurances that no part of the grant funds will be used either by the grantee or by any contractor or subcontractor to be paid from grant funds for any purpose which is inconsistent with regulations promulgated by the Secretary (part 18 of this chapter) implementing title VI of the Civil Rights Act of 1964, or inconsistent with Executive Order 11246 (30 FR 12319) and any implementing regulations the Secretary of Labor may promulgate.

[33 FR 6011, Apr. 19, 1968, as amended at 36 FR 320, Jan. 9, 1971; 42 FR 54804, Oct. 11, 1977. Redesignated and amended at 61 FR 21966, 21969, May 13, 1996]

### § 17.255 Applications for grants for programs which include construction projects.

In addition to the documents and evidence required by § 17.254, any application for a grant for the construction of any facility, structure or system which is part of an exchange of information program shall include the following:

(a) Each application shall include complete descriptions, maps, and surveys of the construction site, and documentary evidence and explanations showing ownership, and

(b) Each application shall include complete plans and specifications for the construction project, and where applicable, sufficient explanations of technical applications so that they may be understood by the layman, and

(c) Each application shall contain assurance that the rates of pay for laborers and mechanics engaged in construction activities will not be less than the prevailing local wage rates for similar work as determined in accordance with the provisions of 40 U.S.C. 276a—276a–5 (The Davis-Bacon Act).

[33 FR 6012, Apr. 19, 1968. Redesignated and amended at 61 FR 21966, 21969, May 13, 1996]

### § 17.256 Amended or supplemental applications.

An amended application, or an application for a supplemental grant, may be considered either before or after final action has been taken on the original application. Amended applications and applications for supplemental grants shall be subject to the same terms, conditions and requirements necessary for original applications.

[33 FR 6012, Apr. 19, 1968. Redesignated at 61 FR 21966, May 13, 1996]

### § 17.257 Awards procedures.

Applications for grants for planning or implementing agreements for the exchange of medical information or information facilities shall be reviewed by the Under Secretary for Health or designee. If it is determined approval of the grant is warranted, recommendations to that effect shall be made to the Secretary in writing and shall be accompanied by the following:

(a) The recommendation for approval shall be accompanied by the written recommendation of the Subcommittee on Academic Affairs, and

(b) The recommendation for approval shall be accompanied by the written draft of the certificate of award stating all conditions which the grantee is required to agree to under the provisions of §17.258 and all other conditions to which it has been determined the grant will be subject, and

(c) The recommendation shall include a certification that sufficient appropriated funds are available, and that the application for the grant is sufficient in all details as specified in §§17.254 through 17.256.

[33 FR 6012, Apr. 19, 1968, as amended at 42 FR 54805, Oct. 11, 1977. Redesignated and amended at 61 FR 21966, 21969, May 13, 1996]

### § 17.258 Terms and conditions to which awards are subject.

Each certificate of award of a grant for planning or implementing an agreement for the exchange of information or information facilities shall specify that the grant is subject to the following terms and conditions:

(a) *Grants subject to terms of agreement for exchange of information.* Each grant shall be subject to, and the certificate shall incorporate by reference, all terms, conditions, and obligations specified in the agreement or planning protocols which the grant will implement, and

(b) *Grants subject to assurances in application.* Each grant shall be subject to all assurances made by the grantee in its application for the grant as required by §§17.254 through 17.256, and

(c) *Grants subject to limitations on use of funds.* Each grant shall be subject to the limitations on the use of grant funds, either for direct or indirect costs, as prescribed in §§17.259 through 17.261, and

(d) *Grants subject to special provisions.* Each grant shall be subject to any special terms or conditions which may be warranted by circumstances applicable to individual applications, and specified in the certificate of award.

[33 FR 6012, Apr. 19, 1968. Redesignated and amended at 61 FR 21966, 21969, May 13, 1996]

### § 17.259 Direct costs.

Direct costs to which grant funds may be applied may include in proportion to time and effort spent, but are not limited to, fees and costs directly paid to personnel or for fringe benefits, rent, publications, educational programs, training, research, demonstration activities, or construction carried out in connection with pilot programs for planning or exchange of information.

[33 FR 6012, Apr. 19, 1968. Redesignated at 61 FR 21966, May 13, 1996]

### § 17.260 Patient care costs to be excluded from direct costs.

Grant funds for planning or implementing agreements for the exchange of medical information shall not be available for the payment of any hospital, medical, or other costs involving

the care of patients except to the extent that such costs are determined to be incident to research, training, or demonstration activities carried out in connection with an exchange of information program.

[33 FR 6012, Apr. 19, 1968. Redesignated at 61 FR 21966, May 13, 1996]

### § 17.261 Indirect costs.

The grantee shall allocate expenditures as between direct and indirect costs according to generally accepted accounting procedures. The amount allocated for indirect costs may be computed on a percentage basis or on the basis of a negotiated lump-sum allowance. In the method of computation used, only indirect costs shall be included which bear a reasonable relationship to the planning or program funded by the grant and shall not exceed a percentage greater than the percentage the total institutional indirect cost is of the total direct salaries and wages paid by the institution.

[33 FR 6012, Apr. 19, 1968. Redesignated at 61 FR 21966, May 13, 1996]

### § 17.262 Authority to approve applications discretionary.

Notwithstanding any recommendation by the Subcommittee on Academic Affairs of the Special Medical Advisory Group, or any recommendation by the Under Secretary for Health or designee, the final determination on any application for a grant rests solely with the Secretary.

[42 FR 54805, Oct. 11, 1977. Redesignated and amended at 61 FR 21966, 21969, May 13, 1996]

### § 17.263 Suspension and termination procedures.

Termination of a grant means the cancellation of Department of Veterans Affairs sponsorship, in whole or in part, under an agreement at any time prior to the date of completion. Suspension of a grant is an action by the Department of Veterans Affairs which temporarily suspends Department of Veterans Affairs sponsorship under the grant pending corrective action by the grantee or pending a decision to terminate the grant by the Department of Veterans Affairs.

(a) *Posttermination appeal.* The following procedures are applicable for reviewing postaward disputes which may arise in the administration of or carrying out of the Exchange of Medical Information Grant Program.

(1) *Reviewable decisions.* The Department of Veterans Affairs reserves the right to terminate any grant in whole or in part at any time before the date of completion, whenever it determines that the grantee has failed to comply with conditions of the agreement, or otherwise failed to comply with any law, regulation, assurance, term, or condition applicable to the grant.

(2) *Notice.* The Department of Veterans Affairs shall promptly notify the grantee in writing of the determination. The notice shall set forth the reason for the determination in sufficient detail to enable the grantee to respond, and shall inform the grantee of his or her opportunity for review by the Assistant Chief Medical Director as provided in this section.

(3) *Request for appeal.* A grantee with respect to whom a determination described in paragraph (a)(1) of this section has been made, and who desires review, may file with the Assistant Chief Medical Director for Academic Affairs an application for review of such determination. The grantee's application for review must be post-marked no later than 30 days after the postmarked date of notification provided pursuant to paragraph (a)(2) of this section.

(4) *Contents of request.* The application for review must clearly identify the question or questions in dispute, contain a full statement of the grantee's position in respect to such question or questions, and provide pertinent facts and reasons in support of his or her position. The Assistant Chief Medical Director for Academic Affairs will promptly send a copy of the grantee's application to the Department of Veterans Affairs official responsible for the determination which is to be reviewed.

(5) *Effect of submission.* When an application for review has been filed no action may be taken by the Department of Veterans Affairs pursuant to such determination until such application has been disposed of, except that the filing of the application shall not affect

the authority which the constituent agency may have to suspend the system under a grant during proceedings under this section or otherwise to withhold or defer payments under the grant.

(6) *Consideration of request.* When an application for review has been filed with the Assistant Chief Medical Director for Academic Affairs, and it has been determined that the application meets the requirements stated in this paragraph, all background material of the issues shall be reviewed. If the application does not meet the requirements, the grantee shall be notified of the deficiencies.

(7) *Presentation of case.* If the Assistant Chief Medical Director for Academic Affairs believes there is no dispute as to material fact, the resolution of which would be materially assisted by oral testimony, both parties shall be notified of the issues to be considered, and take steps to afford both parties the opportunity for presenting their cases, at the option of the Assistant Chief Medical Director for Academic Affairs, in whole or in part in writing, or in an informal conference. Where it is concluded that oral testimony is required to resolve a dispute over a material fact, both parties shall be afforded an opportunity to present and cross-examine witnesses at a hearing.

(8) *Decision.* After both parties have presented their cases, the Assistant Chief Medical Director for Academic Affairs shall prepare an initial written decision which shall include findings of fact and conclusions based thereon. Copies of the decision shall be mailed promptly to each of the parties together with a notice informing them of their right to appeal the decision of the Secretary, or to the officer or employee to whom the Secretary has delegated such authority, by submitting written comments thereon within a specified reasonable time.

(9) *Final decision.* Upon filing comments with the Secretary, or designated officer or employee, the review of the initial decision shall be conducted on the basis of the decision, the hearing record, if any, and written comments submitted by both parties. The decision shall be final.

(10) *Participation by a party.* Either party may participate in person, or by counsel pursuant to the procedure set forth in this section.

(b) *Termination for convenience.* The Department of Veterans Affairs or the grantee may terminate a grant in whole or in part when both parties agree that the continuation of the project would not produce beneficial results commensurate with the further expenditure of funds. The two parties shall agree upon the termination conditions, including the effective date and, in the case of partial terminations, the portion to be terminated. The grantee shall not incur new obligations for the terminated portion after the effective date, and shall cancel as many outstanding obligations as possible. The Department of Veterans Affairs shall allow full credit to the grantee for the Department of Veterans Affairs share of the noncancellable obligations, properly incurred by the grantee prior to termination.

(c) *Suspension procedures.* When a grantee has failed to comply with the terms of the grant agreement and conditions or standards, the Department of Veterans Affairs may, on reasonable notice to the grantee, suspend the grant and withhold further payments, prohibit the grantee from incurring additional obligations of funds, pending corrective action by the grantee, or make a decision to terminate as described in paragraph (a) of this section. The Department of Veterans Affairs shall allow all necessary and proper costs that the grantee could not reasonably avoid during the period of suspension provided that they meet the provisions of the applicable Federal cost principles.

[42 FR 54805, Oct. 11, 1977. Redesignated at 61 FR 21966, May 13, 1996]

### § 17.264 Recoupments and releases.

In any case where the Department of Veterans Affairs or a grantee's obligations under an exchange of information agreement implemented by grant funds are terminated, or where grant-financed equipment or facilities cease to be used for the purposes for which grant support was given, or when grant-financed property is transferred,

the grantee shall return the proportionate value of such equipment or facility as was financed by the grant. When it is determined the Department of Veterans Affairs equitable interest is greater that proportionate value, then a claim in such greater amount shall be asserted. If it is determined an amount less than proportionate value or less than the Department of Veterans Affairs equitable interest should be recouped, or that the Department of Veterans Affairs should execute any releases, then a proposal concerning such a settlement or releases complete with explanations and justifications shall be submitted to the Assistant Chief Medical Director for Academic Affairs for a final determination.

[42 FR 54805, Oct. 11, 1977. Redesignated at 61 FR 21966, May 13, 1996]

### § 17.265 Payments.

Payments of grant funds are made to grantees through a letter-of-credit, an advance by Treasury check, or a reimbursement by Treasury check, as appropriate. A letter-of-credit is an instrument certified by an authorized official of the Department of Veterans Affairs which authorizes the grantee to draw funds when needed from the Treasury, through a Federal Reserve bank and the grantee's commercial bank and shall be used by the Department of Veterans Affairs where all the following conditions exist:

(a) When there is or will be a continuing relationship between the grantee and the Department of Veterans Affairs for at least a 12-month period and the total amount of advance payments expected to be received within that period is $250,000, or more;

(b) When the grantee has established or demonstrated the willingness and ability to maintain procedures that will minimize the time elapsing between the transfer of funds and their disbursement by the grantee; and

(c) When the grantee's financial management meets the standards for fund control and accountability. An advance by Treasury check is a payment made to a grantee upon its request before outlays are made by the grantee, or through use of predetermined payment schedules and shall be used by the Department of Veterans Affairs when the grantee meets all of the above requirements of this section except that advances will be less than $250,000, or for a period less than 12 months. Reimbursement by Treasury check is a payment made to a grantee upon request for reimbursement from the grantee and shall be the preferred method when the grantee does not meet the requirements of paragraphs (b) and (c) of this section. This method may be used on any construction agreement, or if the major portion of the program is accomplished through private market financing or Federal loans, and the Federal assistance constitutes a minor portion of the program. When the reimbursement method is used, the Department of Veterans Affairs shall make payment within 30 days after receipt of the billing, unless billing is improper. Unless otherwise required by law, payments shall not be withheld for proper charges at any time during the grant period unless a grantee has failed to comply with the program objectives, award conditions, or Federal reporting requirements; or the grantee is indebted.

[42 FR 54806, Oct. 11, 1977. Redesignated at 61 FR 21966, May 13, 1996]

### § 17.266 Copyrights and patents.

If a grant-supported program results in copyrightable material or patentable inventions or discoveries, the United States Government shall have the right to use such publications or inventions on a royalty-free basis.

[33 FR 6013, Apr. 19, 1968. Redesignated at 61 FR 21966, May 13, 1996]

## CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE DEPARTMENT OF VETERANS AFFAIRS (CHAMPVA)—MEDICAL CARE FOR SURVIVORS AND DEPENDENTS OF CERTAIN VETERANS

SOURCE: 63 FR 48102, Sept. 9, 1998, unless otherwise noted.

### § 17.270 General provisions.

(a) CHAMPVA is the Civilian Health and Medical Program of the Department of Veterans Affairs and is administered by the Health Administration Center, Denver, Colorado. Pursuant to

38 U.S.C. 1713, VA is authorized to provide medical care in the same or similar manner and subject to the same or similar limitations as medical care furnished to certain dependents and survivors of active duty and retired members of the Armed Forces. The CHAMPVA program is designed to accomplish this purpose. Under CHAMPVA, VA shares the cost of medically necessary services and supplies for eligible beneficiaries as set forth in §§ 17.271 through 17.278.

(b) For purposes of this section, the definitions of ''child,'' ''service-connected condition/disability,'' ''spouse,'' and ''surviving spouse'' must be those set forth further in 38 U.S.C. 101. The term ''fiscal'' year refers to October 1, through September 30.

(Authority: 38 U.S.C. 1713)

### § 17.271 Eligibility.

(a) The following persons are eligible for CHAMPVA benefits provided that they are not eligible for CHAMPUS/TRICARE or Medicare Part A (except as noted in § 17.271).

(1) The spouse or child of a veteran who has been adjudicated by VA as having a permanent and total service-connected disability;

(2) The surviving spouse or child of a veteran who died as a result of an adjudicated service-connected condition(s); or who at the time of death was adjudicated permanently and totally disabled from a service-connected condition(s);

(3) The surviving spouse or child of a person who died on active military service and in the line of duty and not due to such person's own misconduct; and

(4) An eligible child who is pursuing a full-time course of instruction approved under 38 U.S.C. Chapter 36, and who incurs a disabling illness or injury while pursuing such course (between terms, semesters or quarters; or during a vacation or holiday period) that is not the result of his or her own willful misconduct and that results in the inability to continue or resume the chosen program of education must remain eligible for medical care until:

(i) The end of the six-month period beginning on the date the disability is removed; or

(ii) The end of the two-year period beginning on the date of the onset of the disability; or

(iii) The twenty-third birthday of the child, whichever occurs first.

(Authority: 38 U.S.C. 1713)

(b) Persons who lose eligibility for CHAMPVA by becoming potentially eligible for Medicare Part A as a result of reaching age 65 or who qualify for Medicare Part A benefits on the basis of a disability, including end stage renal disease, may re-establish CHAMPVA eligibility by submitting documentation from the Social Security Administration (SSA) certifying their non-entitlement to or exhaustion of Medicare Part A benefits. Persons under age 65 who are enrolled in both Medicare Part A and B may become potentially eligible for CHAMPVA as a secondary payer to Medicare. In cases where CHAMPVA eligibility is restored upon exhaustion of Medicare benefits, CHAMPVA coverage will extend even during subsequent periods of Medicare eligibility. When both CHAMPVA and Medicare eligibility exist, CHAMPVA must be the secondary payer.

(Authority: 38 U.S.C. 1713(d))

NOTE TO § 17.271: Eligibility criteria specific to Dependency and Indemnity Compensation (DIC) benefits are not applicable to CHAMPVA eligibility determinations.

### § 17.272 Benefits limitations/exclusions.

(a) Benefits cover allowable expenses for medical services and supplies that are medically necessary and appropriate for the treatment of a condition and that are not specifically excluded from program coverage. Covered benefits may have limitations. The fact that a physician may prescribe, order, recommend, or approve a service or supply does not, of itself, make it medically necessary or make the charge an allowable expense, even though it is not listed specifically as an exclusion. The following are specifically excluded from program coverage:

(1) Services, procedures or supplies for which the beneficiary has no legal obligation to pay, or for which no charge would be made in the absence of coverage under a health benefits plan.

(2) Services and supplies required as a result of an occupational disease or injury for which benefits are payable under workers' compensation or similar protection plan (whether or not such benefits have been applied for or paid) except when such benefits are exhausted and are otherwise not excluded from CHAMPVA coverage.

(3) Services and supplies that are paid directly or indirectly by a local, State or Federal government agency (Medicaid excluded), including court-ordered treatment. In the case of the following exceptions, CHAMPVA assumes primary payer status:

(i) Medicaid.

(ii) State Victims of Crime Compensation Programs.

(4) Services and supplies that are not medically or psychologically necessary for the diagnosis or treatment of a covered condition (including mental disorder) or injury.

(5) Radiology, laboratory, and pathological services and machine diagnostic testing not related to a specific illness or injury or a definitive set of symptoms.

(6) Services and supplies above the appropriate level required to provide necessary medical care.

(7) Services and supplies related to an inpatient admission primarily to perform diagnostic tests, examinations, and procedures that could have been and are performed routinely on an outpatient basis.

(8) Postpartum inpatient stay of a mother for purposes of staying with the newborn infant (primarily for the purpose of breast feeding the infant) when the infant (but not the mother) requires the extended stay; or continued inpatient stay of a newborn infant primarily for purposes of remaining with the mother when the mother (but not the newborn infant) requires extended postpartum inpatient stay.

(9) Therapeutic absences from an inpatient facility or residential treatment center (RTC).

(10) Custodial care.

(11) Inpatient stays primarily for domiciliary care purposes.

(12) Inpatient stays primarily for rest or rest cures.

(13) Services and supplies provided as a part of, or under, a scientific or medical study, grant, or research program.

(14) Services and supplies not provided in accordance with accepted professional medical standards or related to experimental or investigational procedures or treatment regimens.

(15) Services or supplies prescribed or provided by a member of the beneficiary's immediate family, or a person living in the beneficiary's or sponsor's household.

(16) Services and supplies that are (or are eligible to be) payable under another medical insurance or program, either private or governmental, such as coverage through employment or Medicare.

(17) Services or supplies subject to preauthorization (see § 17.273) that were obtained without the required preauthorization; and services and supplies that were not provided according to the terms of the preauthorization.

(18) Inpatient stays primarily to control or detain a runaway child, whether or not admission is to an authorized institution.

(19) Services and supplies (to include prescription medications) in connection with cosmetic surgery which is performed to primarily improve physical appearance or for psychological purposes or to restore form without correcting or materially improving a bodily function.

(20) Electrolysis.

(21) Dental care with the following exceptions:

(i) Dental care that is medically necessary in the treatment of an otherwise covered medical condition, is an integral part of the treatment of such medical condition, and is essential to the control of the primary medical condition.

(ii) Dental care required in preparation for, or as a result of, radiation therapy for oral or facial cancer.

(iii) Gingival Hyperplasia.

(iv) Loss of jaw substance due to direct trauma to the jaw or due to treatment of neoplasm.

(v) Intraoral abscess when it extends beyond the dental alveolus.

(vi) Extraoral abscess.

(vii) Cellulitis and osteitis which is clearly exacerbating and directly affecting a medical condition currently under treatment.

(viii) Repair of fracture, dislocation, and other injuries of the jaw, to include removal of teeth and tooth fragments only when such removal is incidental to the repair of the jaw.

(ix) Treatment for stabilization of myofascial pain dysfunction syndrome, also referred to as temporomandibular joint (TMJ) syndrome. Authorization is limited to initial radiographs, up to four office visits, and the construction of an occlusal splint.

(x) Total or complete ankyloglossia.

(xi) Adjunctive dental and orthodontic support for cleft palate.

(xii) Prosthetic replacement of jaw due to trauma or cancer.

(22) Nonsurgical treatment of obesity or morbid obesity for dietary control or weight reduction (with the exception of gastric bypass, gastric stapling, or gastroplasty procedures in connection with morbid obesity when determined to be medically necessary) including prescription medications.

(23) Services and supplies related to transsexualism or other similar conditions such as gender dysphoria (including, but not limited to, intersex surgery and psychotherapy, except for ambiguous genitalia which was documented to be present at birth).

(24) Sex therapy, sexual advice, sexual counseling, sex behavior modification, psychotherapy for mental disorders involving sexual deviations (e.g., transvestic fetish), or other similar services, and any supplies provided in connection with therapy for sexual dysfunctions or inadequacies.

(25) Removal of corns or calluses or trimming of toenails and other routine foot care services, except those required as a result of a diagnosed systemic medical disease affecting the lower limbs, such as severe diabetes.

(26) Services and supplies, to include psychological testing, provided in connection with a specific developmental disorder. The following exception applies: Diagnostic and evaluative services required to arrive at a differential diagnosis for an otherwise eligible child unless the state is required to provide those services under Public Law 94–142, *Education for All Handicapped Children Act of 1975 as amended, see 20 U.S.C. chapter 33.*

(27) Surgery to reverse voluntary surgical sterilization procedures.

(28) Services and supplies related to artificial insemination (including semen donors and semen banks), in vitro fertilization, gamete intrafallopian transfer and all other noncoital reproductive technologies.

(29) Nonprescription contraceptives.

(30) Diagnostic tests to establish paternity of a child; or tests to determine sex of an unborn child.

(31) Preventive care (such as routine, annual, or employment-requested physical examinations; routine screening procedures; and immunizations). The following exceptions apply:

(i) Well-child care from birth to age six. Periodic health examinations designed for prevention, early detection, and treatment of disease are covered to include screening procedures, immunizations, and risk counseling. The following services are payable when required as part of a well-child care program and when rendered by the attending pediatrician, family physician, or a pediatric nurse practitioner.

(A) Newborn examination, heredity and metabolic screening, and newborn circumcision.

(B) Periodic health supervision visits intended to promote optimal health for infants and children to include the following services:

(*1*) History and physical examination.

(*2*) Vision, hearing, and dental screening.

(*3*) Developmental appraisal to include body measurement.

(*4*) Immunizations as recommended by the Centers for Disease Control (CDC) and Prevention Advisory Committee on Immunization Practices.

(*5*) Pediatric blood lead level test.

(*6*) Tuberculosis screening.

(*7*) Blood pressure screening.

(*8*) Measurement of hemoglobin and hematocrit for anemia.

(*9*) Urinalysis.

(C) Additional services or visits required because of specific findings or because the particular circumstances of the individual case are covered if medically necessary and otherwise authorized for benefits under CHAMPVA.

(ii) Rabies vaccine following an animal bite.

(iii) Tetanus vaccine following an accidental injury.

(iv) Rh immune globulin.

(v) Pap smears.

(vi) Mammography tests.

(vii) Genetic testing and counseling determined to be medically necessary.

(viii) Chromosome analysis in cases of habitual abortion or infertility.

(ix) Gamma globulin.

(32) Chiropractic and naturopathic services.

(33) Counseling services that are not medically necessary in the treatment of a diagnosed medical condition (such as educational counseling; vocational counseling; and counseling for socio-economic purposes, stress management, life style modification, etc.).

(34) Acupuncture, whether used as a therapeutic agent or as an anesthetic.

(35) Hair transplants, wigs, or hairpieces, except that benefits may be extended for one wig or hairpiece per beneficiary (lifetime maximum) when the attending physician certifies that alopecia has resulted from treatment of malignant disease and the beneficiary certifies that a wig or hairpiece has not been obtained previously through the U.S. Government (including the Department of Veterans Affairs). The wig or hairpiece benefit does not include coverage for the following:

(i) Maintenance, wig or hairpiece supplies, or replacement of the wig or hairpiece.

(ii) Hair transplant or any other surgical procedure involving the attachment of hair or a wig or hairpiece to the scalp.

(iii) Any diagnostic or therapeutic method or supply intended to encourage hair growth.

(36) Self-help, academic education or vocational training services and supplies.

(37) Exercise equipment, spas, whirlpools, hot tubs, swimming pools, health club membership or other such charges or items.

(38) General exercise programs, even if recommended by a physician.

(39) Services of an audiologist or speech therapist, except when prescribed by a physician and rendered as a part of treatment addressed to the physical defect itself and not to any educational or occupational deficit.

(40) Eye exercises or visual training (orthoptics).

(41) Eye and hearing examinations except when rendered in connection with medical or surgical treatment of a covered illness or injury or in connection with well-child care.

(42) Eyeglasses, spectacles, contact lenses, or other optical devices with the following exceptions:

(i) When necessary to perform the function of the human lens, lost as a result of intraocular surgery, ocular injury or congenital absence.

(ii) Pinhole glasses prescribed for use after surgery for detached retina.

(iii) Lenses prescribed as ''treatment'' instead of surgery for the following conditions:

(A) Contact lenses used for treatment of infantile glaucoma.

(B) Corneal or scleral lenses prescribed in connection with treatment of keratoconus.

(C) Scleral lenses prescribed to retain moisture when normal tearing is not present or is inadequate.

(D) Corneal or scleral lenses prescribed to reduce a corneal irregularity other than astigmatism.

(iv) The specified benefits are limited to one set of lenses related to one qualifying eye condition as set forth in paragraphs (a)(42)(iii)(A) through (D) of this section. If there is a prescription change requiring a new set of lenses, but still related to the qualifying eye condition, benefits may be extended for a second set of lenses, subject to medical review.

(43) Hearing aids or other auditory sensory enhancing devices.

(44) Prostheses with the following exceptions:

(i) Artificial limbs.

(ii) Voice prostheses.

(iii) Eyes.

(iv) Items surgically inserted in the body as an integral part of a surgical procedure.

(v) Dental prostheses specifically required in connection with otherwise covered orthodontia directly related to the surgical correction of a cleft palate anomaly.

(45) Orthopedic shoes, arch supports, shoe inserts, and other supportive devices for the feet, including special ordered, custom-made built-up shoes, or regular shoes later built up with the following exceptions:

(i) Shoes that are an integral part of an orthopedic brace, and which cannot be used separately from the brace.

(ii) Extra-depth shoes with inserts or custom molded shoes with inserts for individuals with diabetes.

(46) Services or advice rendered by telephone are excluded except that a diagnostic or monitoring procedure which incorporates electronic transmission of data or remote detection and measurement of a condition, activity, or function (biotelemetry) is covered when:

(i) The procedure, without electronic data transmission, is a covered benefit; and

(ii) The addition of electronic data transmission or biotelemetry improves the management of a clinical condition in defined circumstances; and

(iii) The electronic data or biotelemetry device has been classified by the U.S. Food and Drug Administration, either separately or as part of a system, for use consistent with the medical condition and clinical management of such condition.

(47) Air conditioners, humidifiers, dehumidifiers, and purifiers.

(48) Elevators.

(49) Alterations to living spaces or permanent features attached thereto, even when necessary to accommodate installation of covered durable medical equipment or to facilitate entrance or exit.

(50) Items of clothing, even if required by virtue of an allergy (such as cotton fabric versus synthetic fabric and vegetable-dyed shoes).

(51) Food, food substitutes, vitamins or other nutritional supplements, including those related to prenatal care for a home patient whose condition permits oral feeding.

(52) Enuretic (bed-wetting) devices; enuretic conditioning programs.

(53) Autopsy and post-mortem examinations.

(54) All camping, even when organized for a specific therapeutic purpose (such as diabetic camp or a camp for emotionally disturbed children), or when offered as a part of an otherwise covered treatment plan.

(55) Housekeeping, homemaker, or attendant services, including a sitter or companion.

(56) Personal comfort or convenience items, such as beauty and barber services, radio, television, and telephone.

(57) Smoking cessation services and supplies.

(58) Megavitamin psychiatric therapy; orthomolecular psychiatric therapy.

(59) All transportation except for specialized transportation with life sustaining equipment, when medically required for the treatment of a covered condition.

(60) Inpatient mental health services in excess of 30 days in any fiscal year (or in an admission), in the case of a patient nineteen years of age or older; 45 days in any fiscal year (or in an admission), in the case of a patient under 19 years of age; or 150 days of residential treatment care in any fiscal year (or in an admission) unless a waiver for extended coverage is granted in advance.

(61) Outpatient mental health services in excess of 23 visits in a fiscal year unless a waiver for extended coverage is granted in advance.

(62) Institutional services for partial hospitalization in excess of 60 treatment days in any fiscal year (or in an admission) unless a waiver for extended coverage is granted in advance.

(63) Detoxification in a hospital setting or rehabilitation facility in excess of seven days.

(64) Outpatient substance abuse services in excess of 60 visits during a benefit period. A benefit period begins with the first date of covered service and ends 365 days later.

(65) Family therapy for substance abuse in excess of 15 visits during a benefit period. A benefit period begins with the first date of covered service and ends 365 days later.

(66) Services that are provided to a beneficiary who is referred to a provider of such services by a provider who has an economic interest in the facility to which the patient is referred, unless a waiver is granted.

(67) Abortion except when a physician certifies that the life of the mother would be endangered if the fetus were carried to term.
(68) Abortion counseling.
(69) Aversion therapy.
(70) Rental or purchase of biofeedback equipment.
(71) Biofeedback therapy for treatment of ordinary muscle tension states (including tension headaches) or for psychosomatic conditions.
(72) Drug maintenance programs where one addictive drug is substituted for another, such as methadone substituted for heroin.
(73) Immunotherapy for malignant diseases except for treatment of Stage O and Stage A carcinoma of the bladder.
(74) Services and supplies provided by other than a hospital, such as nonskilled nursing homes, intermediate care facilities, halfway houses, homes for the aged, or other institutions of similar purpose.
(75) Services performed when the patient is not physically present.
(76) Medical photography.
(77) Special tutoring.
(78) Surgery for psychological reasons.
(79) Treatment of premenstrual syndrome (PMS).
(80) Medications not requiring a prescription, except for insulin and related diabetic testing supplies and syringes.
(81) Thermography.
(82) Removal of tattoos.
(83) Penile implant/testicular prosthesis procedures and related supplies for psychological impotence.
(84) Dermabrasion of the face except in those cases where coverage has been authorized for reconstructive or plastic surgery required to restore body form following an accidental injury or to revise disfiguring and extensive scars resulting from neoplastic surgery.
(85) Chemical peeling for facial wrinkles.
(86) Panniculectomy, body sculpting procedures.
(b) CHAMPVA-determined allowable amount.
(1) The term allowable amount is the maximum CHAMPVA-determined level of payment to a hospital or other authorized institutional provider, a physician or other authorized individual professional provider, or other authorized provider for covered services. The CHAMPVA-allowable amount is determined prior to cost sharing and the application of deductibles and/or other health insurance.
(2) A Medicare-participating hospital must accept the CHAMPVA-determined allowable amount for inpatient services as payment-in-full. (Reference 42 CFR parts 489 and 1003).
(3) An authorized provider of covered medical services or supplies must accept the CHAMPVA-determined allowable amount as payment-in-full.
(4) A provider who has collected and not made appropriate refund, or attempts to collect from the beneficiary, any amount in excess of the CHAMPVA-determined allowable amount may be subject to exclusion from Federal benefit programs.

(Authority: 38 U.S.C. 1713)

### § 17.273 Preauthorization.

Preauthorization or advance approval is required for any of the following:
(a) Non-emergent inpatient mental health and substance abuse care including admission of emotionally disturbed children and adolescents to residential treatment centers.
(b) All admissions to a partial hospitalization program (including alcohol rehabilitation).
(c) Outpatient mental health visits in excess of 23 per calendar year and/or more than two (2) sessions per week.
(d) Dental care.
(e) Durable medical equipment with a purchase or total rental price in excess of $300.00.
(f) Organ transplants.

(Authority: 38 U.S.C. 1713)

### § 17.274 Cost sharing.

(a) With the exception of services obtained through VA medical facilities, CHAMPVA is a cost-sharing program in which the cost of covered services is shared with the beneficiary. In addition to the beneficiary cost share, an

annual (calendar year) outpatient deductible requirement ($50 per beneficiary or $100 per family) must be satisfied prior to the payment of outpatient benefits. There is no deductible for inpatient services. CHAMPVA pays the CHAMPVA-determined allowable amount less the deductible, if applicable, and less the beneficiary cost share. To provide financial protection against the impact of a long-term illness or injury, an annual cost limit or ''catastrophic cap'' has been placed on the beneficiary cost-share amount for covered services and supplies. This annual cap on cost sharing is $7,500 per CHAMPVA-eligible family. Credits to the annual catastrophic cap are limited to the applied annual deductible(s) and the beneficiary cost-share amount. Costs above the CHAMPVA-allowable amount, as well as costs associated with noncovered services are not credited to the catastrophic cap computation.

(b) If the CHAMPVA benefit payment is under $1.00, payment will not be issued. Catastrophic cap and deductible will, however, be credited.

(Authority: 38 U.S.C. 1713)

### § 17.275 Claim filing deadline.

(a) Unless an exception is granted under paragraph (b) of this section, claims for medical services and supplies must be filed with the Center no later than:

(1) One year after the date of service; or

(2) In the case of inpatient care, one year after the date of discharge; or

(3) In the case of retroactive approval for medical services/supplies, 180 days following beneficiary notification of authorization; or

(4) In the case of retroactive approval of CHAMPVA eligibility, 180 days following notification to the beneficiary of authorization for services occurring on or after the date of first eligibility.

(b) Requests for an exception to the claim filing deadline must be submitted, in writing, to the Center and include a complete explanation of the circumstances resulting in late filing along with all available supporting documentation. Each request for an exception to the claim filing deadline will be reviewed individually and considered on its own merit. The Center Director may grant exceptions to the requirements in paragraph (a) if he or she determines that there was good cause for missing the filing deadline. For example, when dual coverage exists CHAMPVA payment, if any, cannot be determined until after the primary insurance carrier has adjudicated the claim. In such circumstances an exception may be granted provided that the delay on the part of the primary insurance carrier is not attributable to the beneficiary. Delays due to provider billing procedures do not constitute a valid basis for an exception.

### § 17.276 Appeal/review process.

Notice of the initial determination regarding payment of CHAMPVA benefits will be provided to the beneficiary on a CHAMPVA Explanation of Benefits (EOB) form. The EOB form is generated by the CHAMPVA automated payment processing system. If a beneficiary disagrees with the determination concerning covered services or calculation of benefits, he or she may request reconsideration. Such requests must be submitted to the Center in writing within one year of the date of the initial determination. The request must state why the beneficiary believes the decision is in error and must include any new and relevant information not previously considered. Any request for reconsideration that does not identify the reason for dispute will be returned to the claimant without further consideration. After reviewing the claim and any relevant supporting documentation, a CHAMPVA benefits advisor will issue a written determination to the beneficiary that affirms, reverses or modifies the previous decision. If the beneficiary is still dissatisfied, within 90 days of the date of the decision he or she may make a written request for review by the Center Director. The Director will review the claim, and any relevant supporting documentation, and issue a decision in writing that affirms, reverses or modifies the previous decision. The decision of the Director with respect to benefit coverage and computation of benefits is final.

(Authority: 38 U.S.C. 1713)

NOTE TO § 17.276: Denial of CHAMPVA benefits based on legal eligibility requirements may be appealed to the Board of Veterans' Appeals in accordance with 38 CFR part 20. Medical determinations are not appealable to the Board. 20 CFR 20.101.

### § 17.277 Third-party liability/medical care cost recovery.

The Center will actively pursue third-party liability/medical care cost recovery in accordance with applicable law.

### § 17.278 Confidentiality of records.

Confidentiality of records will be maintained in accordance with 38 CFR 1.460 through 1.582.

GRANTS TO THE REPUBLIC OF THE PHILIPPINES

### § 17.350 The program of assistance to the Philippines.

The provisions of this section through § 17.370 are applicable to grants to the Republic of the Philippines and to furnishing medical services under 38 U.S.C. 1724 and 1732, and 38 CFR 17.36 through 17.40, and implement the ''Agreement between the Government of the United States of America and the Government of the Republic of the Philippines on the Use of the Veterans Memorial Medical Center and the Provision of Inpatient and Outpatient Medical Care and Treatment of Veterans by the Government of the Philippines and Furnishing of Grants-in-Aid Thereof by the Government of the United States of America,'' dated April 25, 1967 (Treaties and Other International Acts Series 6248), and a subsidiary agreement of the same date, both of which were entered into pursuant to the provisions of 38 U.S.C. 1731–1734. All such implementing regulations have been approved by the Director of the Office of Management and Budget.

[33 FR 5300, Apr. 3, 1968, as amended at 45 FR 47680, July 16, 1980; 47 FR 58250, Dec. 30, 1982; 61 FR 21969, May 13, 1996]

### § 17.351 Grants for the replacement and upgrading of equipment at Veterans Memorial Medical Center.

Grants to assist the Republic of the Philippines in the replacement and upgrading of equipment and in rehabilitating the physical plant and facilities of the Veterans Memorial Medical Center, which the Secretary may make under the authority cited in § 17.350, shall be subject to such terms and conditions as the Secretary may prescribe. Among such terms and conditions to which the grants will be subject, will be advance approval by the U.S. Department of Veterans Affairs of equipment purchases, maintenance or repair projects. The awarding of such grants is further subject to the limitations on available funds in § 17.352.

(Authority: 38 U.S.C. 1732, as amended by Pub. L. 97–72, sec. 107(c)(1))

[33 FR 5300, Apr. 3, 1968, as amended at 45 FR 47680, July 16, 1980; 47 FR 58250, Dec. 30, 1982]

### § 17.352 Amounts and use of grant funds for the replacement and upgrading of equipment.

Grants awarded under § 17.351 shall not exceed the amounts provided by the appropriation acts of the Congress of the United States for the purpose. Funds appropriated for the upgrading and replacement of equipment at the Veterans Memorial Medical Center, or for rehabilitating its equipment, shall remain available in consecutive fiscal years until expanded, but in no event shall exceed the amount of $500,000 per year. It is not intended that such funds will be utilized to expand the medical center facilities. Upgrading of equipment, however, would permit purchase of new and additional equipment not now possessed by the medical center.

(Authority: 38 U.S.C. 1732)

[47 FR 58250, Dec. 30, 1982]

### § 17.355 Awards procedures.

All applications for grants to the Republic of the Philippines under the provisions of § 17.351 shall be submitted to the Under Secretary for Health or a designee for consideration.

(Authority: 38 U.S.C. 1732)

[47 FR 58250, Dec. 30, 1982, as amended at 61 FR 21969, May 13, 1996]

### § 17.362 Acceptance of medical supplies as payment.

Upon request of the Government of the Republic of the Philippines, payment for medical and nursing home

services provided to eligible United States veterans may consist in whole or in part, of available medicines, medical supplies, or equipment furnished by the Department of Veterans Affairs to the Veterans Memorial Medical Center at valuations determined by the Secretary. Such valuations shall not be less than the cost of the items and shall include the cost of transportation, arrastre, brokerage, shipping and handling charges.

(Authority: 38 U.S.C. 1732(a)(2))

[47 FR 58250, Dec. 30, 1982]

### § 17.363 Length of stay.

In computing the length of stay for which payment will be made, the day of admission will be counted, but not the day of discharge, death, or transfer. Where a veteran for whom hospitalization has been authorized in Veterans Memorial Medical Center or a contract facility, is absent from the hospital for a period longer than 24 hours, no payment will be made for hospital care during that absence.

(Authority: 38 U.S.C. 1732)

[47 FR 58250, Dec. 30, 1982]

### § 17.364 Eligibility determinations.

Determinations of legal eligibility and medical need for hospitalization of United States veterans for treatment rest exclusively with the United States Department of Veterans Affairs. Determinations as to various factors upon which eligibility may depend shall be made as follows:

(a) *Determinations of service connection.* For the purpose of meeting any requirement in 38 U.S.C. 1724 and 1732, and 38 CFR 17.36 through 17.37 for service-connected disability, the United States Department of Veterans Affairs shall determine that under laws it administers the disability in question was incurred in or aggravated by service, and

(b) *Determinations of valid service.* For the purpose of determining the necessary prerequisite service, determinations by the Department of Defense of the United States as to military service shall be accepted. In those cases in which the United States Department of Veterans Affairs shall have information which it deems reliable and in conflict with the information upon which the Department of Defense determination was made, the conflicting information shall be referred to the Department of Defense for reconsideration and redetermination. Such determinations and redeterminations as to military service shall be conclusive.

(Authority: 38 U.S.C. 1712)

[47 FR 58250, Dec. 30, 1982, as amended at 61 FR 21969, May 13, 1996]

### § 17.365 Admission priorities.

Appropriate provisions of § 17.49 apply.

(Authority: 38 U.S.C. 1712)

[47 FR 58251, Dec. 30, 1982]

### § 17.366 Authorization of emergency admissions.

The Secretary of National Defense of the Republic of the Philippines shall make determinations as to whether any patient should be admitted in emergency circumstances before the U.S. Department of Veterans Affairs has made a legal determination of eligibility, except that liability for payment will not accrue to the United States until such eligibility determination has been made. Eligibility determinations will be given effect retroactively to the date of admission when the U.S. Department of Veterans Affairs has been notified by telephone, telegram, letter, or other communication of the emergency admission within 72 hours of the hour of admission. The Clinic Director of the VA Regional Office, Manila, may make an exception to the 72-hour limitation when it is determined that the delay in notification was fully justified. When any authorization cannot be made effective retroactively to the date of admission, it shall be effective from the date of receipt of notification.

[33 FR 5301, Apr. 3, 1968, as amended at 47 FR 58251, Dec. 30, 1982]

### § 17.367 Republic of the Philippines to print forms.

The Secretary of National Defense of the Republic of the Philippines will, with the concurrence of the Secretary of Veterans Affairs, print all forms for

applications for hospitalization, forms for physical examination reports, forms for billings for services rendered, and such other forms as may be necessary and incident to the efficient execution of the program governed by the provisions of 38 U.S.C. 1724 and 1732, and 38 CFR 17.36 through 17.40 and §§17.350 through 17.370. The forms will be used whenever applicable in the general operation of the program.

[33 FR 5301, Apr. 3, 1968, as amended at 61 FR 21969, May 13, 1996]

### § 17.369 Inspections.

The U.S. Department of Veterans Affairs, through authorized representatives, has the right under the agreements cited in §17.350, to inspect the Veterans Memorial Medical Center, its premises and all appurtenances and records to determine completeness and correctness of such records, and to determine according to the provisions of the cited agreements whether standards maintained conform to the necessary requirements.

[33 FR 5301, Apr. 3, 1968, as amended at 47 FR 58251, Dec. 30, 1982]

### § 17.370 Termination of payments.

Payments may be terminated if the U.S. Department of Veterans Affairs determines the Veterans Memorial Medical Center has not replaced and upgraded as needed equipment during the period in which the agreements cited in §17.50 are in effect or has not rehabilitated the existing physical plant and facilities to place the medical center on a sound and effective operating basis, or has not maintained the medical center in a well-equipped and effective operating condition. Payments, however, will not be stopped unless the Veterans Memorial Medical Center has been given at least 60 days advance written notice of intent to stop payments.

(Authority: 38 U.S.C. 1732)

[33 FR 5301, Apr. 3, 1968, as amended at 47 FR 58251, Dec. 30, 1982]

## CONFIDENTIALITY OF HEALTHCARE QUALITY ASSURANCE REVIEW RECORDS

AUTHORITY: 38 U.S.C. 5705.

SOURCE: 59 FR 53355, Oct. 24, 1994, unless otherwise noted.

### § 17.500 General.

(a) Section 5705, title 38, United States Code was enacted to protect the integrity of the VA's medical quality assurance program by making confidential and privileged certain records and documents generated by this program and information contained therein. Disclosure of quality assurance records and documents made confidential and privileged by 38 U.S.C. 5705 and the regulations in §§17.500 through 17.511 may only be made in accordance with the provisions of 38 U.S.C. 5705 and those regulations.

(b) The purpose of the regulations in §§17.500 through 17.511 is to specify and provide for the limited disclosure of those quality assurance documents which are confidential under the provisions of 38 U.S.C. 5705.

(c) For purposes of the regulations in §§17.500 through 17.511, the VA's medical quality assurance program consists of systematic healthcare reviews carried out by or for VA for the purpose of improving the quality of medical care or improving the utilization of healthcare resources in VA medical facilities. These review activities may involve continuous or periodic data collection and may relate to either the structure, process, or outcome of health care provided in the VA.

(d) Nothing in the regulations in §§17.500 through 17.511 shall be construed as authority to withhold any record or document from a committee or subcommittee of either House of Congress or any joint committee or subcommittee of Congress, if such record or document pertains to any matter within the jurisdiction of such committee or joint committee.

(e) The regulations in §§17.500 through 17.511 do not waive the sovereign immunity of the United States, and do not waive the confidentiality provisions and disclosure restrictions of 38 U.S.C. 5705.

(Authority: 38 U.S.C. 5705)

### § 17.501 Confidential and privileged documents.

(a) Documents and parts of documents are considered confidential and

privileged if they were produced by or for the VA in the process of conducting systematic healthcare reviews for the purpose of improving the quality of health care or improving the utilization of healthcare resources in VA healthcare facilities and meet the criteria in paragraphs (b) and (c) of this section. The four classes of healthcare quality assurance reviews with examples are:

(1) Monitoring and evaluation reviews conducted by a facility:

(i) Medical records reviews,

(ii) Drug usage evaluations,

(iii) Blood usage reviews,

(iv) Surgical case/invasive procedure reviews,

(v) Service and program monitoring including monitoring performed by individual services or programs, several services or programs working together, or individuals from several services or programs working together as a team,

(vi) Mortality and morbidity reviews,

(vii) Infection control review and surveillance,

(viii) Occurrence screening,

(ix) Tort claims peer reviews (except reviews performed to satisfy the requirements of a governmental body or a professional health care organization which is licensing practitioners or monitoring their professional performance),

(x) Admission and continued stay reviews,

(xi) Diagnostic studies utilization reviews,

(xii) Reports of special incidents (VA Form 10-2633 or similar forms) and follow-up documents unless developed during or as a result of a Board of Investigation;

(2) Focused reviews which address specific issues or incidents and which are designated by the reviewing office at the outset of the review as protected by 38 U.S.C. 5705 and the regulations in §§17.500 through 17.511; focused reviews may be either:

(i) Facility focused reviews;

(ii) VA Central Office or Regional focused reviews;

(3) VA Central Office or Regional general oversight reviews to assess facility compliance with VA program requirements if the reviews are designated by the reviewing office at the outset of the review as protected by 38 U.S.C. 5705 and the regulations in §§17.500 through 17.511; and

(4) Contracted external reviews of care, specifically designated in the contract or agreement as reviews protected by 38 U.S.C. 5705 and the regulations in §§17.500 through 17.511.

(b) The Under Secretary for Health, Regional Director or facility Director will describe in advance in writing those quality assurance activities included under the classes of healthcare quality assurance reviews listed in paragraph (a) of this section. Only documents and parts of documents resulting from those activities which have been so described are protected by 38 U.S.C. 5705 and the regulations in §§17.500 through 17.511. If an activity is not described in a VA Central Office or Regional policy document, this requirement may be satisfied at the facility level by description in advance of the activity and its designation as protected in the facility quality assurance plan or other policy document.

(c) Documents and parts of documents generated by activities which meet the criteria in paragraphs (a) and (b) of this section shall be confidential and privileged only if they:

(1) Identify, either implicitly or explicitly, individual practitioners, patients, or reviewers except as provided in paragraph (g)(6) of this section; or

(2) Contain discussions relating to the quality of VA medical care or utilization of VA medical resources by healthcare evaluators during the course of a review of quality assurance information or data, even if they do not identify practitioners, patients, or reviewers; or

(3) Are individual committee, service, or study team minutes, notes, reports, memoranda, or other documents either produced by healthcare evaluators in deliberating on the findings of healthcare reviews, or prepared for purposes of discussion or consideration by healthcare evaluators during a quality assurance review; or

(4) Are memoranda, letters, or other documents from the medical facility to the Regional Director or VA Central Office which contain information generated by a quality assurance activity

meeting the criteria in §17.501 (a) and (b); or

(5) Are memoranda, letters, or other documents produced by the Regional Director or VA Central Office which either respond to or contain information generated by a quality assurance activity meeting the criteria in §17.501 (a) and (b).

(d) Documents which meet the criteria in this section are confidential and privileged whether they are produced at the medical facility, Regional or VA Central Office levels, or by external contractors performing healthcare quality assurance reviews.

(e) Documents which are confidential and privileged may be in written, computer, electronic, photographic or any other form.

(f) Documents which contain confidential and privileged material in one part, but not in others, such as Clinical Executive Board minutes, should be filed and maintained as if the entire document was protected by 38 U.S.C. 5705. This is not required if the confidential and privileged material is deleted.

(g) The following records and documents and parts of records and documents are not confidential even if they meet the criteria in paragraphs (a) through (c) of this section:

(1) Statistical information regarding VA healthcare programs or activities that does not implicitly or explicitly identify individual VA patients or VA employees or individuals involved in the quality assurance process;

(2) Summary documents or records which only identify study topics, the period of time covered by the study, criteria, norms, and/or major overall findings, but which do not identify individual healthcare practitioners, even by implication;

(3) The contents of Credentialing and Privileging folders as described in VACO policy documents (38 U.S.C. 5705-protected records shall not be filed in Credentialing and Privileging folders);

(4) Records and documents developed during or as a result of Boards of Investigations;

(5) Completed patient satisfaction survey questionnaires and findings from patient satisfaction surveys;

(6) Records and documents which only indicate the number of patients treated by a practitioner, either by diagnosis or in aggregate, or number of procedures performed by a practitioner, either by procedure or in aggregate;

(7) Records and documents developed during or as a result of reviews performed to satisfy the requirements of a governmental body or a professional healthcare organization which is licensing practitioners or monitoring their professional performance, e.g., National Practitioner Data Bank, Federation of State Medical Boards, and National Council of State Boards of Nursing;

(8) Documents and reports developed during or as a result of site visits by the Office of the Medical Inspector except to the extent that the documents and reports contain information that meets the criteria described in this section and are produced by or for VA by other than the Office of Medical Inspector;

(9) External reviews conducted by VA Central Office or a Region other than those designated by the reviewing office under paragraph (a)(2) or (a)(3) of this section as protected by 38 U.S.C. 5705 and the regulations in §§17.500 through 17.511;

(10) Documents and reports of Professional Standards Boards, Credentialing Committees, Executive Committees of Medical Staff, and similar bodies, insofar as the documents relate to the credentialing and privileging of practitioners;

(11) Documents and reports developed during or as a result of data validation activities;

(12) Documents and reports developed during or as a result of occupational health monitoring;

(13) Documents and reports developed during or as a result of safety monitoring not directly related to the care of specified individual patients;

(14) Documents and reports developed during or as a result of resource management activities not directly related to the care of specified individual patients; and

(15) Information and records derived from patient medical records or facility administrative records, which are

not protected by 38 U.S.C. 5705 and the regulations in §§17.500 through 17.511, may be sent or communicated to a third party payor who has asked for this information in response to a VA request for reimbursement based on Public Law 99–272 and Public Law 101–508. Reviews conducted at the request of the third party payor do not generate records protected by 38 U.S.C. 5705 and the regulations in §§17.500 through 17.511 since the reviews are not undertaken as part of the VA's quality assurance program.

(Authority: 38 U.S.C. 5705)

### § 17.502 Applicability of other statutes.

(a) Disclosure of quality assurance records and documents which are not confidential and privileged under 38 U.S.C. 5705 and the confidentiality regulations in §§17.500 through 17.511 will be governed by the provisions of the Freedom of Information Act, and, if applicable, the Privacy Act and any other VA or federal confidentiality statutes.

(b) When included in a quality assurance review, confidential records protected by other confidentiality statutes such as 5 U.S.C. 552a (the Privacy Act), 38 U.S.C. 7332 (drug and alcohol abuse, sickle cell anemia, HIV infection), and 38 U.S.C. 5701 (veterans' names and addresses) retain whatever confidentiality protection they have under these laws and applicable regulations and will be handled accordingly. To the extent that information protected by 38 U.S.C. 5701 or 7332 or the Privacy Act is incorporated into quality assurance records, the information in the quality assurance records is still protected by these statutes.

(Authority: 38 U.S.C. 5705)

### § 17.503 Improper disclosure.

(a) Improper disclosure is the disclosure of confidential and privileged healthcare quality assurance review records or documents (or information contained therein), as defined in §17.501, to any person who is not authorized access to the records or documents under the statute and the regulations in §§17.500 through 17.511.

(b) ''Disclosure'' means the communication, transmission, or conveyance in any way of any confidential and privileged quality assurance records or documents or information contained in them to any individual or organization in any form by any means.

(Authority: 38 U.S.C. 5705)

### § 17.504 Disclosure methods.

(a) Disclosure of confidential and privileged quality assurance records and documents or the information contained therein outside VA, where permitted by the statute and the regulations in §§17.500 through 17.511, will always be by copies, abstracts, summaries, or similar records or documents prepared by the Department of Veterans Affairs and released to the requestor. The original confidential and privileged quality assurance records and documents will not be removed from the VA facility by any person, VA employee or otherwise, except in accordance with §17.508(c) or where otherwise legally required.

(b) Disclosure of confidential and privileged quality assurance records and documents to authorized individuals under either §17.508 or §17.509 shall bear the following statement: ''These documents or records (or information contained herein) are confidential and privileged under the provisions of 38 U.S.C. 5705, which provide for fines up to $20,000 for unauthorized disclosures thereof, and the implementing regulations. This material shall not be disclosed to anyone without authorization as provided for by that law or the regulations in §§17.500 through 17.511.''

(Authority: 38 U.S.C. 5705)

### § 17.505 Disclosure authorities.

The VA medical facility Director, Regional Director, Under Secretary for Health, or their designees are authorized to disclose any confidential and privileged quality assurance records or documents under their control to other agencies, organizations, or individuals where 38 U.S.C. 5705 or the regulations in §§17.500 through 17.511 expressly provide for disclosure.

(Authority: 38 U.S.C. 5705)

### § 17.506 Appeal of decision by Veterans Health Administration to deny disclosure.

When a request for records or documents subject to the regulations in §§ 17.500 through 17.511 is denied in whole or in part by the VA medical facility Director, Regional Director or Under Secretary for Health, the VA official denying the request in whole or in part will notify the requestor in writing of the right to appeal this decision to the General Counsel of the Department of Veterans Affairs within 60 days of the date of the denial letter. The final Department decision will be made by the General Counsel or the Deputy General Counsel.

(Authority: 38 U.S.C. 5705)

### § 17.507 Employee responsibilities.

(a) All VA employees and other individuals who have access to records designated as confidential and privileged under 38 U.S.C. 5705 and the regulations in §§ 17.500 through 17.511 will treat the findings, views, and actions relating to quality assurance in a confidential manner.

(b) All individuals who have had access to records designated as confidential and privileged under 38 U.S.C. 5705 and the regulations in §§ 17.500 through 17.511 will not disclose such records or information therein to any person or organization after voluntary or involuntary termination of their relationship to the VA.

(Authority: 38 U.S.C. 5705)

### § 17.508 Access to quality assurance records and documents within the agency.

(a) Access to confidential and privileged quality assurance records and documents within the Department pursuant to this section is restricted to VA employees (including consultants and contractors of VA) who have a need for such information to perform their government duties or contractual responsibilities and who are authorized access by the VA medical facility Director, Regional Director, the Under Secretary for Health, or their designees or by the regulations in §§ 17.500 through 17.511.

(b) To foster continuous quality improvement, practitioners on VA rolls, whether paid or not, will have access to confidential and privileged quality assurance records and documents relating to evaluation of the care they provided.

(c) Any quality assurance record or document, whether confidential and privileged or not, may be provided to the General Counsel or any attorney within the Office of General Counsel, wherever located. These documents may also be provided to a Department of Justice (DOJ) attorney who is investigating a claim or potential claim against the VA or who is preparing for litigation involving the VA. If necessary, such a record or document may be removed from the VA medical facility to the site where the General Counsel or any attorney within the Office of General Counsel or the DOJ attorney is conducting an investigation or preparing for litigation.

(d) Any quality assurance record or document or the information contained therein, whether confidential and privileged or not, will be provided to the Department of Veterans Affairs Office of Inspector General upon request. A written request is not required.

(e) To the extent practicable, documents accessed under paragraph (b) of this section will not include the identity of peer reviewers. Reasonable efforts will be made to edit documents so as to protect the identities of reviewers, but the inability to completely do so will not bar access under paragraph (b).

(f) No individual shall be permitted access to confidential and privileged quality assurance records and documents identified in § 17.501 unless such individual has been informed of the penalties for unauthorized disclosure. Any misuse of confidential and privileged quality assurance records or documents shall be reported to the appropriate VHA official, e.g., Service Chief, Medical Center Director.

(g) In general, confidential and privileged quality assurance records and documents will be maintained for a minimum of 3 years and may be held longer if needed for research studies or quality assurance or legal purposes.

(Authority: 38 U.S.C. 5705)

**§ 17.509 Authorized disclosure: Non-Department of Veterans Affairs requests.**

(a) Requests for confidential and privileged quality assurance records and documents from organizations or individuals outside VA must be made to the Department and must specify the nature and content of the information requested, to whom the information should be transmitted or disclosed, and the purpose listed in paragraphs (b) through (j) of this section for which the information requested will be used. In addition, the requestor will specify to the extent possible the beginning and final dates of the period for which disclosure or access is requested. The request must be in writing and signed by the requestor. Except as specified in paragraphs (b) and (c) of this section, these requests should be forwarded to the Director of the facility in possession of the records or documents for response. The procedures outlined in 38 CFR 1.500 through 1.584 will be followed where applicable.

(b) Disclosure shall be made to Federal agencies upon their written request to permit VA's participation in healthcare programs including healthcare delivery, research, planning, and related activities with the requesting agencies. Any Federal agency may apply to the Under Secretary for Health for approval. If the VA decides to participate in the healthcare program with the requestor, the requesting agency will enter into an agreement with VA to ensure that the agency and its staff will ensure the confidentiality of any quality assurance records or documents shared with the agency.

(c) Qualified persons or organizations, including academic institutions, engaged in healthcare program activities shall, upon request to and approval by the Under Secretary for Health, Regional Director, medical facility Director, or their designees, have access to confidential and privileged medical quality assurance records and documents to permit VA participation in a healthcare activity with the requestor, provided that no records or documents are removed from the VA facility in possession of the records.

(d) When a request under paragraphs (b) or (c) of this section concerns access for research purposes, the request, together with the research plan or protocol, shall first be submitted to and approved by an appropriate VA medical facility Research and Development Committee and then approved by the Director of the VA medical facility. The VA medical facility staff together with the qualified person(s) conducting the research shall be responsible for the preservation of the anonymity of the patients, clients, and providers and shall not disseminate any records or documents which identify such individuals directly or indirectly without the individual's consent. This applies to the handling of data or information as well as reporting or publication of findings. These requirements are in addition to other applicable protections for the research.

(e) Individually identified patient medical record information which is protected by another statute as provided in §17.502 may not be disclosed to a non-VA person or organization, including disclosures for research purposes under paragraph (d), except as provided in that statute.

(f) Under paragraph (b), the Under Secretary for Health or designee or under paragraph (c), the Under Secretary for Health, Regional Director, medical facility Director, or their designees may approve a written request if it meets the following criteria:

(1) Participation by VA will benefit VA patient care; or

(2) Participation by VA will enhance VA medical research; or

(3) Participation by VA will enhance VA health services research; or

(4) Participation by VA will enhance VA healthcare planning or program development activities; or

(5) Participation by VA will enhance related VA healthcare program activities; and

(6) Access to the record by the requester is required for VA to participate in a healthcare program with the requester.

(g) Protected quality assurance records or documents, including records pertaining to a specific individual, will for purposes authorized under law be disclosed to a civil or

criminal law enforcement governmental agency or instrumentality charged under applicable law with the protection of public health or safety, including state licensing and disciplinary agencies, if a written request for such records or documents is received from an official of such an organization. The request must state the purpose authorized by law for which the records will be used. The Under Secretary for Health, Regional Director, medical facility Director, or their designees will determine the extent to which the information is disclosable.

(h) Federal agencies charged with protecting the public health and welfare, federal and private agencies which engage in various monitoring and quality control activities, agencies responsible for licensure of individual health care facilities or programs, and similar organizations will be provided confidential and privileged quality assurance records and documents if a written request for such records or documents is received from an official of such an organization. The request must state the purpose for which the records will be used. The Under Secretary for Health, Regional Director, medical facility Director, or their designees will determine the extent to which the information is disclosable.

(i) JCAHO (Joint Commission on Accreditation of Healthcare Organizations) survey teams and similar national accreditation agencies or boards and other organizations requested by VA to assess the effectiveness of quality assurance program activities or to consult regarding these programs are entitled to disclosure of confidential and privileged quality assurance documents with the following qualifications:

(1) Accreditation agencies which are charged with assessing all aspects of medical facility patient care, e.g., JCAHO, may have access to all confidential and privileged quality assurance records and documents.

(2) Accreditation agencies charged with more narrowly focused review (e.g., College of American Pathologists, American Association of Blood Banks, Nuclear Regulatory Commission, etc.) may have access only to such confidential and privileged records and documents as are relevant to their respective focus.

(j) Confidential and privileged quality assurance records and documents shall be released to the General Accounting Office if such records or documents pertain to any matter within its jurisdiction.

(k) Confidential and privileged quality assurance records and documents shall be released to both VA and non-VA healthcare personnel upon request to the extent necessary to meet a medical emergency affecting the health or safety of any individual.

(l) For any disclosure made under paragraphs (a) through (i) of this section, the name of and other identifying information regarding any individual VA patient, employee, or other individual associated with VA shall be deleted from any confidential and privileged quality assurance record or document before any disclosure under these quality assurance regulations in §§ 17.500 through 17.511 is made, if disclosure of such name and identifying information would constitute a clearly unwarranted invasion of personal privacy.

(m) Disclosure of the confidential and privileged quality assurance records and documents identified in § 17.501 will not be made to any individual or agency until that individual or agency has been informed of the penalties for unauthorized disclosure or redisclosure.

(Authority: 38 U.S.C. 5705)

### § 17.510 Redisclosure.

No person or entity to whom a quality assurance record or document has been disclosed under § 17.508 or § 17.509 shall make further disclosure of such record or document except as provided for in 38 U.S.C. 5705 and the regulations in §§ 17.500 through 17.511.

(Authority: 38 U.S.C. 5705)

### § 17.511 Penalties for violations.

Any person who knows that a document or record is a confidential and privileged quality assurance document or record described in §§ 17.500 through

17.511 and willfully discloses such confidential and privileged quality assurance record or document or information contained therein, except as authorized by 38 U.S.C. 5705 or the regulations in §§17.500 through 17.511, shall be fined not more than $5,000 in the case of a first offense and not more than $20,000 in the case of each subsequent offense.

(Authority: 38 U.S.C. 5705)

## VA HEALTH PROFESSIONAL SCHOLARSHIP PROGRAM

AUTHORITY: 38 U.S.C. 7601–7655.

### § 17.600 Purpose.

The purpose of §§17.600 through 17.612 is to set forth the requirements for the award of scholarships under the Department of Veterans Affairs Health Professional Scholarship Program to students receiving education or training in a direct or indirect health-care services discipline to assist in providing an adequate supply of such personnel for VA and for the Nation. Disciplines include nursing, physical therapy, occupational therapy, and other specified direct or indirect health-care disciplines if needed by VA.

[55 FR 40170, Oct. 2, 1990]

### § 17.601 Definitions.

For the purpose of these regulations:

(a) *Acceptable level of academic standing* means the level at which a student retains eligibility to continue in attendance in school under the school's standards and practices in the course of study for which the scholarship was awarded.

(b) *Act* means the Department of Veterans Affairs Health-Care Amendments of 1980, Pub. L. 96–330, (38 U.S.C. 7601–7655), as amended by Pub. L. 97–251, the Department of Veterans Affairs Health-Care Programs Improvement and Extension Act of 1982, Pub. L. 99–576, Veterans Benefits Improvement and Health Care Authorization Act of 1986, and Pub. L. 100–322, the Veterans' Benefits and Services Act of 1988.

(Authority: Pub. L. 96–330; 38 U.S.C. 7601–7655, as amended by Pub. L. 97–251; Pub. L. 99–576 and Pub. L. 100–322)

(c) *Affiliation agreement* means a Memorandum of Affiliation between a Department of Veterans Affairs health care facility and a school of medicine or osteopathy.

(d) *Advanced clinical training* means those programs of graduate training in medicine including osteopathy which (1) lead to eligibility for board certification or which provide other evidence of completion, and (2) have been approved by the appropriate body as determined by the Administrator.

(e) *Secretary* means the Secretary of Veterans Affairs or designee.

(f) *Under Secretary for Health* means the Under Secretary for Health for Veterans Health Administration or designee.

(g) *Citizen of the United States* means any person born, or lawfully naturalized in the United States, subject to its jurisdiction and protection, and owing allegiance thereto.

(h) *Degree* means a course of study leading to a doctor of medicine, doctor of osteopathy, doctor of dentistry, doctor of optometry, doctor of podiatry, or an associate degree, baccalaureate degree, or master's degree in a nursing specialty needed by VA; or a baccalaureate or master's degree in another direct or indirect health-care service discipline needed by VA.

(i) *Full-time student* means an individual pursuing a course of study leading to a degree who is enrolled for a sufficient number of credit hours in any academic term to complete the course of study within not more than the number of academic terms normally required by the school, college or university. If an individual is enrolled in a school and is pursuing a course of study which is designed to be completed in more than 4 years, the individual will be considered a full-time student for only the last 4 years of the course study.

(j) *Other educational expenses* means a reasonable amount of funds determined by the Secretary to cover expenses such as books, and laboratory equipment.

(k) *Required educational equipment* means educational equipment which must be rented or purchased by all students pursuing a similar curriculum in the same school.

(l) *Required fees* means those fees which are charged by the school to all students pursuing a similar curriculum in the same school.

(m) *Scholarship Program* or *Scholarship* means the Department of Veterans Affairs Health Professional Scholarship Program authorized by section 216 of the Act.

(n) *Participant* or *Scholarship Program Participant* means an individual whose application to the Scholarship Program has been approved and whose contract has been accepted by the Secretary and who has yet to complete the period of obligated service or otherwise satisfy the obligation or financial liabilities of the Scholarship Contract.

(o) *School* means an academic institution which (1) provides training leading to a degree in a direct or indirect health-care service discipline needed by the Department of Veterans Affairs, and (2) which is accredited by a body or bodies recognized for accreditation by the Secretary.

(Authority: 38 U.S.C. 7602(a))

(p) *School year* means, for purposes of the stipend payment, all or part of the 12-month period from September 1 through August 31 during which a participant is enrolled in the school as a full-time student.

(q) *State* means one of the several States, Territories and possessions of the United States, the District of Columbia and the Commonwealth of Puerto Rico.

(r) *Part-time student* means an individual who is a Department of Veterans Affairs employee permanently assigned to a Department of Veterans Affairs health care facility who has been accepted for enrollment or enrolled for study leading to a degree on a less than full-time but not less than half-time basis.

(s) *Department of Veterans Affairs employee* means an individual employed and permanently assigned to a VA health care facility.

(t) *Degree completion date* means the date on which a participant completes all requirements of the degree program.

(Authority: 38 U.S.C. 7452)

(u) *VA health care facility* means Department of Veterans Affairs medical centers, medical and regional office centers, domiciliaries, independent outpatient clinics, and outpatient clinics in regional offices.

(Authority: 38 U.S.C. 7633)

(Approved by the Office of Management and Budget under control number 2900–0352)

[47 FR 10810, Mar. 12, 1982, as amended at 48 FR 37399, Aug. 18, 1983; 54 FR 28674, July 7, 1989; 55 FR 40170, Oct. 2, 1990; 61 FR 21969, May 13, 1996]

### § 17.602 Eligibility.

(a) To be eligible for a scholarship under this program an applicant must—

(1) Be accepted for enrollment or be enrolled as a full-time student in an accredited school located in a State;

(2) Be pursuing a degree annually designated by the Secretary for participation in the Scholarship Program;

(Authority: 38 U.S.C. 7602(a)(1), 7612(b)(1))

(3) Be in a discipline or program annually designated by the Secretary for participation in the Scholarship Program;

(4) Be a citizen of the United States; and

(5) Submit an application to participate in the Scholarship Program together with a signed contract.

(Authority: 38 U.S.C. 7602(a))

(b) To be eligible for a scholarship as a part-time student under this program, an applicant must satisfy requirements of paragraph (a) of this section and in addition must—

(1) Be a full-time VA employee permanently assigned to a VA health care facility at the time of application and on the date when the scholarship is awarded;

(2) Remain a VA employee for the duration of the scholarship award.

(Authority: 38 U.S.C. 7612(c)(3)(B))

(c) Any applicant who, at the time of application, owes a service obligation to any other entity to perform service after completion of the course of study is ineligible to receive a scholarship

under the Department of Veterans Affairs Scholarship Program.

(Authority: 38 U.S.C. 7602(b))

(Approved by the Office of Management and Budget under control number 2900–0352)

[47 FR 10810, Mar. 12, 1982, as amended at 48 FR 37399, Aug. 18, 1983; 54 FR 28674, July 7, 1989]

### § 17.603 Availability of scholarships.

Scholarships will be awarded only when necessary to assist the Department of Veterans Affairs in alleviating shortages or anticipated shortages of personnel in particular health professions. The existence of a shortage of personnel will be determined in accordance with specific criteria for each health profession, promulgated by the Under Secretary for Health. The Secretary has the authority to determine the number of scholarships to be awarded in a fiscal year, and the number that will be awarded to full-time and part-time students.

(Authority: 38 U.S.C. 7612(b)(4) and 7603(b)(1))

[54 FR 28674, July 7, 1989, as amended at 61 FR 21969, May 13, 1996]

### § 17.604 Application for the scholarship program.

Each individual desiring a scholarship under this program must submit an accurate and complete application in the form and at the time prescribed by the Secretary. Included with the application will be a signed written contract to accept payment of a scholarship and to serve *a period of obligated service* (as defined in §17.607) if the application is approved and if the contract is accepted by the Secretary.

(Authority: 38 U.S.C. 7612(c)(1)(B))

[47 FR 10810, Mar. 12, 1982]

### § 17.605 Selection of participants.

(a) *General.* In deciding which Scholarship Program applications will be approved by the Secretary, priority will be given to applicants entering their final year of education or training and priority will be given to applicants who previously received scholarship awards and who meet the conditions of paragraph (d) of this section. Except for continuation awards (see paragraph (d) of this section), applicants will be evaluated under the criteria specified in paragraph (b) of this section. A situation may occur in which there are a larger number of equally qualified applicants than there are awards to be made. In such cases, a random method may be used as the basis for selection. In selecting participants to receive awards as part-time students, the Secretary may, at the Secretary's discretion—

(Authority: 38 U.S.C. 7612(b)(5))

(1) Award scholarships geographically to part-time students so that available scholarships may be distributed on a relatively equal basis to students working throughout the VA health care system, and/or

(2) Award scholarships on the basis of retention needs within the VA health care system.

(Authority: 38 U.S.C. 7603(d))

(b) *Selection.* In evaluating and selecting participants, the Secretary will take into consideration those factors determined necessary to assure effective participation in the Scholarship Program. The factors may include, but not be limited to—

(1) Work/volunteer experience, including prior health care employment and Department of Veterans Affairs employment;

(2) Faculty and employer recommendations;

(3) Academic performance; and

(4) Career goals.

(Authority: 38 U.S.C. 7633)

(c) *Selection of part-time students.* Factors in addition to those specified in paragraph (b) of this section, which may be considered in awarding scholarships to part-time students may include, but are not limited to:

(1) Length of service of a VA employee in a health care facility;

(2) Honors and awards received from VA, and other sources;

(3) VA work performance evaluation;

(4) A recommendation for selection for a part-time scholarship from a VA Medical District.

(Authority: 38 U.S.C. 7452(d)(1))

(d) *Duration of scholarship award.* Subject to the availability of funds for

the Scholarship Program, the Secretary will award a participant a full-time scholarship under these regulations for a period of from 1 to 4 school years and a participant of a part-time scholarship for a period of 1 to 6 school years.

(Authority: 38 U.S.C. 7612(c)(1)(A) and 7614(3))

(e) *Continuation awards.* Subject to the availability of funds for the Scholarship Program and selection, the Secretary will award a continuation scholarship for completion of the degree for which the scholarship was awarded if—

(1) The award will not extend the total period of Scholarship Program support beyond 4 years for a full-time scholarship, and beyond 6 years for a part-time scholarship; and

(2) The participant remains eligible for continued participation in the Scholarship Program.

(Authority: 38 U.S.C. 7603(d))

(Approved by the Office of Management and Budget under control number 2900–0352)

[48 FR 37399, Aug. 18, 1983, as amended at 54 FR 28674, July 7, 1989]

### § 17.606 Award procedures.

(a) *Amount of scholarship.* (1) A scholarship award will consist of (i) tuition and required fees, (ii) other educational expenses, including books and laboratory equipment, and (iii) except as provided in paragraph (a)(2) of this section, a monthly stipend, for the duration of the scholarship award. All such payments to scholarship participants are exempt from Federal taxation.

(Authority: 38 U.S.C. 7636)

(2) No stipend may be paid to a participant who is a full-time VA employee.

(3) The Secretary may determine the amount of the stipend paid to participants, whether part-time students or full-time students, but that amount may not exceed the maximum amount provided for in 38 U.S.C. 7613(b).

(4) In the case of a part-time student who is a part-time employee, the maximum stipend, if more than a nominal stipend is paid, will be reduced in accordance with the proportion that the number of credit hours carried by such participant bears to the number of credit hours required to be carried by a full-time student in the course of training being pursued by the participant.

(5) A full stipend may be paid only for the months the part-time student is attending classes.

(Authority: 38 U.S.C. 7614(2))

(6) The Secretary may make arrangements with the school in which the participant is enrolled for the direct payment of the amount of tuition and/or reasonable educational expenses on the participant's behalf.

(Authority: 38 U.S.C. 7613(c))

(7) A participant's eligibility for a stipend ends at the close of the month in which degree requirements are met.

(b) *Leave-of-absence, repeated course work.* The Secretary may suspend scholarship payments to or on behalf of a participant if the school (1) approves a leave-of-absence for the participant for health, personal, or other reasons, or (2) requires the participant to repeat course work for which the Secretary previously has made payments under the Scholarship Program. Additional costs relating to the repeated course work will not be paid under this program. Any scholarship payments suspended under this section will be resumed by the Secretary upon notification by the school that the participant has returned from the leave-of-absense or has satisfactorily completed the repeated course work and is proceeding as a full-time student in the course of study for which the scholarship was awarded.

(Authority: 38 U.S.C. 7633)

[48 FR 37400, Aug. 18, 1983, as amended at 55 FR 40170, Oct. 2, 1990]

### § 17.607 Obligated service.

(a) *General.* Except as provided in paragraph (d) of this section, each participant is obligated to provide service as a Department of Veterans Affairs employee in full-time clinical practice in the participant's discipline in an assignment or location determined by the Secretary.

(Authority: 38 U.S.C. 7616(a))

(b) *Beginning of service.* (1) Except as provided in paragraph (b)(2) of this section, a participant's obligated service

shall begin on the date the Secretary appoints the participant as a full-time VA employee in the Department of Veterans Affairs Veterans Health Administration in a position for which the degree program prepared the participant. The Secretary shall appoint the participant to such position within 60 days after the participant's degree completion date, or the date the participant becomes licensed in a State to practice in the discipline for which the degree program prepared the participant, whichever is later. At least 60 days prior to the appointment date, the Secretary shall notify the participant of the work assignment, its location, and the date work must begin.

(2) Obligated service shall begin on the degree completion date for a participant who, on that date, is a full-time VA employee working in a capacity for which the degree program prepared the participant.

(Authority: 38 U.S.C. 7616 (b) and (c))

(c) *Duration of service.* The period of obligated service for a participant who attended school as a full-time student shall be 1 year for each school year or part thereof for which the participant received a scholarship award under these regulations. The period of obligated service for a participant who attended school as a part-time student shall be reduced from that which a full-time student must serve in accordance with the proportion that the number of credit hours carried by the part-time student in any school year bears to the number of credit hours required to be carried by a full-time student, whichever is the greater, but shall be a minimum of 1 year of full-time employment.

(Authority: 38 U.S.C. 7612(c)(1)(B) and (3)(A))

(d) *Location for service.* The Secretary reserves the right to make final decisions on location for service obligation. A participant who received a scholarship as a full-time student must be willing to move to another geographic location for service obligation. A participant who received a scholarship as a part-time student may be allowed to serve the period of obligated service at the health care facility where the individual was assigned when the scholarship was authorized.

(Authority: 38 U.S.C. 7616(a))

(e) *Creditability of advanced clinical training.* No period of advanced clinical training will be credited toward satisfying the period of obligated service incurred under the Scholarship Program.

(Authority: 38 U.S.C. 7616(b)(3)(A)(ii)

[47 FR 10810, Mar. 12, 1982, as amended at 48 FR 37400, Aug. 18, 1983; 54 FR 28675, July 7, 1989]

### § 17.608 Deferment of obligated service.

(a) *Request for deferment.* A participant receiving a degree from a school of medicine, osteopathy, dentistry, optometry, or podiatry, may request deferment of obligated service to complete an approved program of advanced clinical training. The Secretary may defer the beginning date of the obligated service to allow the participant to complete the advanced clinical training program. The period of this deferment will be the time designated for the specialty training.

(Authority: 38 U.S.C. 7616(a)(A)(i))

(b) *Deferment requirements.* Any participant whose period of obligated service is deferred shall be required to take all or part of the advanced clinical training in an accredited program in an educational institution having an Affiliation Agreement with a Department of Veterans Affairs health care facility, and such training will be undertaken in a Department of Veterans Affairs health-care facility.

(Authority: 38 U.S.C. 7616(b)(4))

(c) *Additional service obligation.* A participant who has requested and received deferment for approved advanced clinical training may, at the time of approval of such deferment and at the discretion of the Secretary and upon the recommendation of the Under Secretary for Health, incur an additional period of obligated service—

(1) At the rate of one-half of a calendar year for each year of approved clinical training (or a proportionate ratio thereof) if the training is in a specialty determined to be necessary to meet health care requirements of the

Veterans Health Administration; Department of Veterans Affairs; or

(2) At the rate of three-quarters of a calendar year for each year of approved graduate training (or a proportionate ratio thereof) if the training is in a medical specialty determined not to be necessary to meet the health care requirements of the Veterans Health Administration. Specialties necessary to meet the health care requirements of the Veterans Health Administration will be prescribed periodically by the Secretary when, and if, this provision for an additional period of obligated service is to be used.

(Authority: 38 U.S.C. 7616(b)(4)(B))

(d) *Altering deferment.* Before altering the length or type of approved advanced clinical training for which the period of obligated service was deferred under paragraphs (a) or (b) of this section, the participant must request and obtain the Secretary's written approval of the alteration.

(Authority: 38 U.S.C. 7633)

(e) *Beginning of service after deferment.* Any participant whose period of obligated service has been deferred under paragraph (a) or (b) of this section must begin the obligated service effective on the date of appointment under title 38 in full-time clinical practice in an assignment or location in a Department of Veterans Affairs health care facility as determined by the Secretary. The assignment will be made by the Secretary within 120 days prior to or no later than 30 days following the completion of the requested graduate training for which the deferment was granted. Travel and relocation regulations will apply.

(Authority: 38 U.S.C. 7616(b)(2))

[47 FR 10810, Mar. 12, 1982; 47 FR 13523, Mar. 31, 1982, as amended at 54 FR 28675, July 7, 1989; 61 FR 21969, May 13, 1996]

### § 17.609 Pay during period of obligated service.

The initial appointment of physicians for obligated service will be made in a grade commensurate with qualifications as determined in section 7404(b)(1) of title 38 U.S.C. A physician serving a period of obligated service is not eligible for incentive special pay during the first three years of such obligated service. A physician may be paid primary special pay at the discretion of the Secretary upon the recommendation of the Under Secretary for Health.

(Authority: Pub. L. 96–330, Sec. 202; 38 U.S.C. 7431–7440)

[47 FR 10810, Mar. 12, 1982, as amended at 54 FR 28676, July 7, 1989; 61 FR 21969, May 13, 1996]

### § 17.610 Failure to comply with terms and conditions of participation.

(a) If a participant, other than one described in paragraph (b) of this section fails to accept payment or instructs the school not to accept payment of the scholarship provided by the Secretary, the participant must, in addition to any service or other obligation incurred under the contract, pay to the United States the amount of $1,500 liquidated damages. Payment of this amount must be made within 90 days of the date on which the participant fails to accept payment of the scholarship award or instructs the school not to accept payment.

(Authority: 38 U.S.C. 7617(a))

(b) If a participant:

(1) Fails to maintain an acceptable level of academic standing;

(2) Is dismissed from the school for disciplinary reasons;

(3) Voluntarily terminates the course of study or program for which the scholarship was awarded including in the case of a full-time student, a reduction of course load from full-time to part-time before completing the course of study or program;

(4) Fails to become licensed to practice in the discipline for which the degree program prepared the participant, if applicable, in a State within 1 year from the date such person becomes eligible to apply for State licensure; or

(Authority: 38 U.S.C. 7617(b)(4))

(5) Is a part-time student and fails to maintain employment in a permanent assignment in a VA health care facility while enrolled in the course of training being pursued; the participant must instead of performing any service obligation, pay to the United States an amount equal to all scholarship funds

awarded under the written contract executed in accordance with §17.602. Payment of this amount must be made within 1 year from the date academic training terminates unless a longer period is necessary to avoid hardship. No interest will be charged on any part of this indebtedness.

(Authority: 38 U.S.C. 7617(b))

(c) Participants who breach their contracts by failing to begin or complete their service obligation (for any reason) other than as provided for under paragraph (b) of this section are liable to repay the amount of all scholarship funds paid to them and to the school on their behalf, plus interest, multiplied by three, minus months of service obligation satisfied, as determined by the following formula:

$$A = 3\Phi\left(\frac{t-s}{t}\right)$$

in which:

'A' is the amount the United States is entitled to recover;

'ϕ' is the sum of the amounts paid to or on behalf of the applicant and the interest on such amounts which would be payable if, at the time the amounts were paid, they were loans bearing interest at the maximum legal prevailing rate, as determined by the Treasurer of the United States;

't' is the total number of months in the applicant's period of obligated service; and

's' is the number of months of the period of obligated service served by the participant.

The amount which the United States is entitled to recover shall be paid within 1 year of the date on which the applicant failed to begin or complete the period of obligated service, as determined by the Secretary.

(Authority: 38 U.S.C. 7617(c)(1)(2))

(Approved by the Office of Management and Budget under control number 2900–0352)

[47 FR 10810, Mar. 12, 1982; 47 FR 13523, Mar. 31, 1982, as amended at 48 FR 37400, Aug. 18, 1983; 54 FR 28676, July 7, 1989; 54 FR 46611, Nov. 6, 1989; 61 FR 24237, May 14, 1996]

### §17.611 Bankruptcy.

Any payment obligation incurred may not be discharged in bankruptcy under title 11 U.S.C. until 5 years after the date on which the payment obligation is due.

(Authority: 38 U.S.C. 7634(c))

[47 FR 10810, Mar. 12, 1982]

### §17.612 Cancellation, waiver, or suspension of obligation.

(a) Any obligation of a participant for service or payment will be canceled upon the death of the participant.

(Authority: 38 U.S.C. 7634(a))

(b)(1) A participant may seek a waiver or suspension of the service or payment obligation incurred under this program by written request to the Secretary setting forth the basis, circumstances, and causes which support the requested action. The Secretary may approve an initial request for a suspension for a period of up to 1 year. A renewal of this suspension may also be granted.

(2) The Secretary may waive or suspend any service or payment obligation incurred by a participant whenever compliance by the participant (i) is impossible, due to circumstances beyond the control of the participant or (ii) whenever the Secretary concludes that a waiver or suspension of compliance would be in the best interest of the Department of Veterans Affairs.

(Authority: 38 U.S.C. 7634(b))

(c) Compliance by a participant with a service or payment obligation will be considered impossible due to circumstances beyond the control of the participant if the Secretary determines, on the basis of such information and documentation as may be required, that the participant suffers from a physical or mental disability resulting in permanent inability to perform the service or other activities which would be necessary to comply with the obligation.

(Authority: 38 U.S.C. 7634(b))

(d) Waivers or suspensions of service or payment obligations, when not related to paragraph (c) of this section,

and when considered in the best interest of the Department of Veterans Affairs, will be determined by the Secretary on an individual basis.

(Authority: 38 U.S.C. 7634(b))

[47 FR 10810, Mar. 12, 1982]

## VA Homeless Providers Grant and Per Diem Program

SOURCE: 59 FR 28265, June 1, 1994, unless otherwise noted.

### § 17.700 Purpose and scope.

(a) *General.* The VA Homeless Providers Grant and Per Diem Program is authorized by sections 3 and 4 of Pub. L. 102–590, the Homeless Veterans Comprehensive Service Programs Act of 1992. The VA Homeless Providers Grant and Per Diem Program is designed to assist eligible entities in establishing new programs to furnish outreach, rehabilitative services, vocational counseling and training, and transitional housing assistance to homeless veterans. Section 3 of the Act provides for grants to eligible entities of up to 65 percent of the estimated cost to construct, expand, remodel or alter existing buildings; to acquire facilities for use as service centers, transitional housing or other facilities to serve homeless veterans; or to procure vans to provide transportation for and support outreach to homeless veterans. A grant may not be used to support operational costs. In addition, §4 of Pub. L. 102–590 authorizes VA to provide to a recipient of a grant under §3 (or entity eligible for such a grant as described in §17.716 of this part) per diem payments for homeless veterans whom VA has referred to that entity; or for whom VA has authorized the provision of services. In lieu of per diem payments, VA may provide in-kind assistance through services of VA employees and the use of other VA resources. This program does not provide for funding to acquire buildings located on VA-owned property. The program does provide for grant funds to be used to construct, expand or remodel buildings located on VA-owned property.

(b) *Components.* (1) Grants may be used for the three components described in §17.702:

(2) Grant recipients or eligible entities may apply for per diem payments or receive in-kind assistance through VA as described in §17.715.

(3) Applicants may apply for a grant for more than one component described in §17.702 and/or per diem payments.

[59 FR 28265, June 1, 1994, as amended at 60 FR 10504, Feb. 27, 1995; 62 FR 6121, Feb. 11, 1997]

### § 17.701 Definitions.

As used in this part:

*Area or community* means a political subdivision or contiguous political subdivisions (such as precinct, ward, borough, city, county, State, Congressional district, etc.) with a separately identifiable population of homeless veterans.

*Capital lease* means a lease that satisfies one of the following criteria:

(1) The lease transfers ownership to the lessee at the expiration of the lease term.

(2) The lessor bears no risk.

(3) The term of the lease exceeds 75 percent of the economic life of the asset.

(4) The lease contains a bargain purchase option.

(5) The present value of lease payments is equal to or greater than 90 percent of the fair market value of the asset.

*Eligible entity* means a public or nonprofit private entity with the capacity to effectively administer a grant under this section; which has demonstrated that adequate financial support will be available to carry out the project for which the grant is sought consistent with the plans, specifications and schedule submitted by the applicant; and which has agreed to, and has demonstrated the capacity to, meet the applicable criteria and requirements of the grant program.

*Expansion of an existing building* means an addition to an existing structure that does not increase the floor area by more than 100 percent.

*Federally recognized Indian tribal government* includes the governing body or a governmental agency of any Indian tribe, band, nation, or other organized group or community (including any Native village as defined in section 3 of the Alaska Native Claims Settlement

Act, 85 Stat 688) certified by the Secretary of the Interior as eligible for the special programs and services provided by him through the Bureau of Indian Affairs.

*Homeless or homeless individual* (1) includes:

(i) An individual who lacks a fixed, regular and adequate nighttime residence; and

(ii) An individual who has a primary nighttime residence that is—

(A) A supervised publicly or privately operated shelter designed to provide temporary living accommodations (including welfare hotels, congregate shelters, and transitional housing for the mentally ill);

(B) An institution that provides a temporary residence for persons intended to be institutionalized; or

(C) A public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings.

(2) The term ''homeless'' or ''homeless individual'' does not include any individual imprisoned or otherwise detained pursuant to an Act of the Congress or a State law. An individual on probation, parole or under electronic custody is not considered ''imprisoned or otherwise detained''.

*New construction* means the building of a structure where none existed or an addition to an existing structure that increases the floor area by more than 100 percent.

*New program/new component of an existing program* means a proposed program of supportive services, or a proposed addition of supportive services to an existing program, which services are not currently being provided by the entity proposing it, and for which there is a demonstrated need in the area or community served by that entity.

*Nonprofit organization* means a private organization, no part of the net earnings of which may inure to the benefit of any member, founder, contributor, or individual. The organization must:

(1) Have a voluntary board;

(2) Have a functioning accounting system that is operated in accordance with generally accepted accounting principles, or designate an entity that will maintain a functioning accounting system for the organization in accordance with generally accepted accounting principles; and

(3) Practice nondiscrimination in the provision of supportive housing and supportive services assistance.

*Operating costs* means expenses incurred in operating supportive housing, supportive services or service centers with respect to:

(1) Administration (including staff salaries; costs associated with accounting for the use of grant funds, preparing reports for submission to VA and obtaining program audits; and similar costs related to administering the grant after the award), maintenance, repair and security for the supportive housing;

(2) Van or building rent (except under capital leases), utilities, insurance, fuel, furnishings, and equipment;

(3) Conducting on-going assessments of supportive services provided for and needed by participants and the availability of such services;

(4) Relocation assistance under §17.730 of this part, including payments and services; and

(5) Other costs associated with operating the supportive housing.

*Outpatient health services* means outpatient health care, outpatient mental health services, outpatient alcohol and/or substance abuse services, and case management.

*Participant* means a person who receives services provided at sites funded with assistance provided under this part.

*Project* means a structure or structures (or portion of such structure or structures) acquired, rehabilitated, or constructed with assistance provided under this part. A project may be used to provide supportive housing or supportive services in single room occupancy dwelling units which may or may not contain bathrooms or kitchen facilities and are appropriate for use as supportive housing.

*Recipient* means any governmental or nonprofit entity that receives assistance under this part.

*Rehabilitation* means the improvement or repair of an existing structure. Rehabilitation does not include minor or routine repairs.

*Secretary* means the Secretary of Veterans Affairs.

*Seriously mentally ill* means having a severe and persistent mental or emotional impairment that seriously limits a person's ability to live independently. This may include an impairment related to substance (alcohol and/or drug) abuse.

*Service center* means a project which provides the supportive services specified at §17.724(k) to homeless veterans for a minimum of 40 hours per week over a minimum of five days per week as well as on an as-needed, unscheduled basis.

*Single room occupancy (SRO) housing* means a unit for occupancy by one person, which need not but may contain food preparation or sanitary facilities, or both.

*Sponsor* means a public or nonprofit organization which owns or leases dwelling units in buildings acquired and/or renovated with funds from this grant program, and which makes such units available to eligible homeless veterans.

*State* means any of the several States of the United States, the District of Columbia, the Commonwealth of Puerto Rico, any territory or possession of the United States, or any agency or instrumentality of a State exclusive of local governments. The term does not include any public and Indian housing agency under United States Housing Act of 1937.

*Supportive housing* means housing in conjunction with which supportive services are provided for homeless veterans where:

(1) The housing is safe and sanitary and meets any applicable State and local housing codes and licensing requirements in the jurisdiction in which the housing is located, and the requirements of this part; and

(2) The housing is:

(i) Transitional housing; or

(ii) Is, or is a part of, a particularly innovative project for, or alternative method of, meeting the immediate and long-term needs of homeless veterans.

*Supportive services* (1) Means services, which may be designed by the recipient or program participants, that

(i) address the special needs of homeless veterans to be served by the project, and

(ii) provide appropriate services or assist such persons in obtaining appropriate services.

(2) Supportive services include:

(i) Outreach activities;

(ii) Providing food, nutritional counseling, counseling, health care, mental health treatment, alcohol and other substance abuse services, case management services;

(iii) Establishing and operating child care services for dependents of homeless veterans;

(iv) Providing supervision and security arrangements necessary for the protection of residents of supportive housing and for homeless veterans using the housing or services;

(v) Providing assistance in obtaining permanent housing;

(vi) Providing education, employment counseling, job training, establishing and operating an employment assistance program;

(vii) Providing assistance in obtaining other Federal, State and local assistance available for such residents including mental health benefits, employment counseling, veterans' benefits, medical assistance, and income support assistance such as Supplemental Security Income benefits, Aid to Families with Dependent Children, General Assistance, Food Stamps, etc.; and

(viii) Providing housing assistance, legal assistance, advocacy, transportation, and other services essential for achieving and maintaining independent living.

(ix) Inpatient acute hospital care does not qualify as a supportive service.

*Transitional housing* means housing that will facilitate the movement of homeless veterans and their dependents to permanent housing within 24 months, or within a longer period as described in §17.724(i) of this part.

*Unit of general local government* means a county, municipality, city, town, township, local public authority (including any public and Indian housing agency under the United States Housing Act of 1937), school district, special district, intrastate district, council of

governments (whether or not incorporated as a nonprofit corporation under state law), any other regional or interstate government entity, or any agency or instrumentality of a local government.

*Veteran* means a person who served in the active military, naval, or air service, and who was discharged or released therefrom under conditions other than dishonorable.

*Veteran with disabilities* means a veteran with a physical, mental, or emotional impairment which is expected to be of long-continued and indefinite duration; substantially impedes his or her ability to live independently; and is of such a nature that such ability could be improved by more suitable housing conditions. This may include a disability related to substance (alcohol and/or drug) abuse. A veteran may be considered to have a disability regardless of whether VA has or has not awarded compensation or a pension for the disability.

[59 FR 28265, June 1, 1994, as amended at 60 FR 10504, Feb. 27, 1995]

### § 17.702 Types and uses of assistance.

(a) *Grant assistance.* Grant assistance is available to:

(1) Construct structures to establish new supportive housing facilities, new facilities to provide supportive services, or to establish service centers;

(2) Acquire, expand and remodel/alter structures to establish new supportive housing facilities, new facilities to provide supportive services, or to establish service centers; and

(3) Procure vans to provide transportation for the purpose of providing supportive services to homeless veterans.

(4) Applicants may apply for more than one type of assistance.

(b) *Limitation on non-veteran participants.* Up to 25 percent of services available in projects funded through this grant program may be provided to participants who are not receiving those services as veterans.

(c) *Structures used for multiple purposes.* Structures funded through this grant program that are used to provide supportive housing, supportive services, or used as service centers may also be used for other purposes, except that assistance under this part will be available only in proportion to the use of the structure for supportive housing, supportive services, or as a service center.

(d) *Maximum amount of grant.* The amount of a grant under this part may not exceed 65 percent of the cost of acquisition, rehabilitation, acquisition and rehabilitation, construction or procurement.

### § 17.703 Grants for acquisition and rehabilitation.

(a) *Use.* VA will grant funds to recipients to:

(1) Pay a portion of the cost of the acquisition of real property selected by the recipients for use in the provision of supportive housing or supportive services, or to establish service centers, including the repayment of any outstanding debt on a loan made to purchase property that has not been used previously for supportive housing, supportive services, or service centers; and

(2) Pay a portion of the cost of rehabilitation of structures, including cost-effective energy measures, selected by the recipients to provide supportive housing or supportive services or to establish service centers.

(b) If grant funds are proposed to be used for acquisition or rehabilitation, the applicant must demonstrate that the costs associated with acquisition or rehabilitation are less than the costs associated with new construction.

### § 17.704 Grants for new construction.

(a) *Use.* VA will grant funds to recipients to pay a portion of the cost of new construction, including cost-effective energy measures and the cost of land associated with that construction, for use in the provision of supportive housing or supportive services, or for service centers. If grant funds are proposed to be used for new construction, the applicant must demonstrate that the costs associated with new construction are less than the costs associated with rehabilitation of an existing building, or that there is a lack of available appropriate units that could be rehabilitated at a cost less than new construction. The applicant must also demonstrate that new construction is less costly than acquisition of an existing

building. For purposes of this cost comparison, costs associated with rehabilitation or new construction may include the cost of real property acquisition.

(b) *Demolition plan.* The cost of demolition of a building cannot be included in the cost of construction unless the proposed construction is in the same location as the building to be demolished or unless the demolition is inextricably linked to the design of the construction project. If the applicant believes that this cost may be included in the cost of the construction project, a demolition plan should be submitted which includes the extent and cost of existing site features to be removed, stored, or relocated.

### § 17.705 Grants for procurement of vans.

(a) *Use.* VA will grant funds to recipients to pay a portion of the cost of procuring vans to provide transportation for and support outreach to homeless veterans.

(b) *Insurance.* Recipients of grants to procure vans who are nonprofit entities must insure vans to the same extent they would insure a van bought with their own funds.

(c) *Amount.* The estimated total costs of purchasing the van may include the purchase price, sales taxes, and title and licensing fees.

### § 17.706 Matching requirements.

(a) *General.* The recipient must, from sources other than grant funds received under this part, match the funds provided by VA to cover the percentage of the total cost of the acquisition, rehabilitation, construction or procurement not funded by the grant. This matching share shall constitute at least 35 percent of the total cost.

(b) *Maintenance of effort.* State or local government funds used in the matching contribution are subject to the maintenance of effort requirements described at § 17.707(a) of this part.

### § 17.707 Limitations on use of assistance.

(a) *Maintenance of effort.* No assistance provided under this part may be used to replace Federal, State or local funds previously used, or designated for use, to assist homeless veterans.

(b) *Primarily religious organizations.* VA will provide assistance to a recipient that is a primarily religious organization if the organization agrees to provide housing and supportive services in a manner that is free from religious influences and the organization complies with the following principles:

(1) It will not discriminate against any employee or applicant for employment on the basis of religion and will not limit employment or give preference in employment to persons on the basis of religion;

(2) It will not discriminate against any person applying for housing or supportive services on the basis of religion and will not limit such housing or services or give preference to persons on the basis of religion;

(3) It will provide no religious instruction or counseling, conduct no religious worship or services, engage in no religious proselytizing, and exert no other religious influence in the provision of housing and supportive services.

### § 17.708 Notice of fund availability (NOFA).

When funds are made available for assistance, VA will publish a notice of fund availability in the FEDERAL REGISTER. The notice will:

(a) Give the location for obtaining application packages, which will provide specific application requirements and guidance;

(b) Specify the date, time, and place for submitting completed applications; and

(c) State the amount and status of funding available under the notice.

### § 17.709 Grant award process.

*General.* The grant award process for assistance under this part consists of the following:

(1) Reviewing applications for eligibility for assistance;

(2) Rating applications (see § 17.711 of this part);

(3) Selecting applications conditionally (see § 17.712 of this part);

(4) Obtaining additional information and awarding grants (see § 17.713 of this part).

### § 17.710 Application requirements.

(a) *General.* Applications for grants must be submitted in the form prescribed by VA in the application package, must meet the requirements of this part, and must be submitted within the time period established by VA in the notice of fund availability under § 17.708 of this part. The application packet includes exhibits to be prepared and submitted as part of the application process, including:

(1) Justification for the project by addressing items listed in § 17.711(c) of this part;

(2) Site description, design, and cost estimates (VA Forms 10–0362G, 10–0362H);

(3) Documentation on eligibility to receive assistance under this part (VA Form 10–0362J);

(4) Documentation on matching funds committed to the projects (VA Forms 10–0362N, 10–0362M);

(5) Documentation on operating budget and cost sharing (VA Form 10–0362P);

(6) Documentation on supportive services committed to the project (VA Form 10–0362o);

(7) Documentation on site control and appropriate zoning, and on the boundaries of the area or community proposed to be served (VA Form 10–0362Q);

(8) Applicants who are States must submit any comments or recommendations by appropriate State (and areawide) clearinghouses pursuant to E.O. 12372 (3 CFR, 1982 Comp., p. 197) (Standard Form SF 424); and

(9) Reasonable assurances with respect to receipt of assistance under this part that (VA Form 10–0362K):

(i) The project will be used principally to furnish to veterans the level of care for which such application is made; that not more than 25 percent of participants at any one time will be nonveterans; and that such services will meet standards prescribed by VA;

(ii) Title to such site or van will vest solely in the applicant;

(iii) Each recipient will keep those records and submit those reports as VA may reasonably require, within the time frames required; and give VA, upon demand, access to the records upon which such information is based; and

(iv) Adequate financial support will be available for the purchase of the van or completion of the project, and for its maintenance, repair and operation.

(b) *Pre-award expenditures.* Costs incurred for a project after the date VA notifies an applicant that the project is feasible for VA participation are allowable costs if the application is approved and the grant is awarded. These pre-award expenditures include architectural and engineering fees. Such notification occurs when VA requests information for the second submission portion of the application.

(Paperwork requirements were approved by the Office of Management and Budget under control number 2900–0554.)

(Authority: 38 U.S.C. 501, 7721, note)

[62 FR 6121, Feb. 11, 1997]

### § 17.711 Rating criteria for applications.

(a) *General.* Applications will be assigned a rating score and placed in ranked order, based upon the criteria listed in paragraphs (b) through (d) of this section.

(b) *Threshold review.* Applicants will undergo a threshold review prior to rating and ranking, to ensure they meet the following:

(1) *Forms, time, and adequacy.* Applications must be filed in the form prescribed by VA in the application process and within the time established in the Notice of Funding Availability (NOFA).

(2) *Application eligibility.* The applicant and project sponsor, if relevant, must be eligible to apply for the specific program.

(3) *Eligible population to be served.* The population proposed to be served must be homeless veterans and meet other eligibility requirements of the specific program.

(4) *Eligible activities.* The activities for which assistance is requested must be eligible for funding under this part (e.g., new programs or new components of existing programs).

(5) *Outstanding audit findings.* No organization that receives assistance may have an outstanding obligation to VA that is in arrears or for which a

payment schedule has not been agreed to, or whose response to an audit is overdue or unsatisfactory.

(c) *Rating and ranking of first submission.* Applicants that pass the threshold review will then be rated using the eight selection criteria listed in paragraphs (c)(1) through (c)(8) of this section. Applicants must receive at least 600 points (out of a possible 1,200) and must receive points under criteria 1, 2, 3, 4, and 8. Applicants that are applying as an innovative supportive housing project must achieve points under the *innovative quality of the proposal* criterion.

(1) Quality of the project—300 points (VA Forms 10–0362A, 10–0362D);

(2) Targeting to persons on streets and in shelters—150 points (VA Form 10–0362C);

(3) Ability of the applicants to develop and operate a project—200 points (VA Form 10–0362E);

(4) Need for the type of project proposed in the area to be served—150 points (VA Form 10–0362B);

(5) Innovative quality of the proposal—50 points (VA Forms 10–0362A, 10–0362D);

(6) Leveraging—50 points (VA Form 10–0362F);

(7) Cost-effectiveness—100 points (VA Form 10–0362A); and

(8) Coordination with other programs—200 points (VA Form 10–0362D–1).

(d) *Selection criteria*—(1) *Quality of the project.* VA will award up to 300 points based on the extent to which the application presents a clear, well-conceived and thorough plan for assisting homeless veterans to achieve residential stability, increased skills and/or income, and more influence over decisions that affect their lives. Higher ratings will be assigned to those applications that clearly describe:

(i) How program participants will achieve residential stability, including how available supportive services will help participants reach this goal;

(ii) How program participants will increase their skill level and/or income, including how available supportive services will help participants reach this goal;

(iii) How program participants will be involved in making project decisions that affect their lives, including how they will be involved in selecting supportive services, establishing individuals goals and developing plans to achieve these goals so that they achieve greater self-determination;

(iv) How permanent affordable housing will be identified and made available to participants upon leaving the transitional housing, and how participants will be provided necessary follow-up services to help them achieve stability in the permanent housing;

(v) How the service needs of participants will be assessed on an ongoing basis;

(vi) How the proposed housing, if any, will be managed and operated;

(vii) How participants will be assisted in assimilating into the community through access to neighborhood facilities, activities and services;

(viii) How and when the progress of participants toward meeting their individual goals will be monitored and evaluated;

(ix) How and when the effectiveness of the overall project in achieving its goals will be evaluated and how program modifications will be made based on those evaluations; and

(x) How the proposed project will be implemented in a timely fashion.

(2) *Targeting to persons on streets and in shelters.* VA will award up to 150 points based on:

(i) The extent to which the project will serve homeless veterans living in places not ordinarily meant for human habitation (e.g., streets, parks, abandoned buildings, automobiles, under bridges, in transportation facilities) and those who reside in emergency shelters; and

(ii) The likelihood that proposed plans for outreach and selection of participants will result in these populations being served.

(3) *Ability of applicant to develop and operate a project.* VA will award up to 200 points based on the extent to which those who will be involved in carrying out the project have experience in activities similar to those proposed in the application. Ratings will be assigned based on the extent to which the application demonstrates experience in the following areas:

(i) Engaging the participation of homeless veterans living in places not ordinarily meant for human habitation and in emergency shelters;

(ii) Assessing the housing and relevant supportive service needs of homeless veterans;

(iii) Accessing housing and relevant supportive service resources;

(iv) If applicable, contracting for and/or overseeing the rehabilitation or construction of housing;

(v) If applicable, administering a rental assistance program;

(vi) Providing supportive services for homeless veterans;

(vii) Monitoring and evaluating the progress of persons toward meeting their individual goals; and

(viii) Evaluating the overall effectiveness of a program and using evaluation results to make program improvements.

(4) *Need.* VA will award up to 150 points based on the applicant's demonstrated understanding of the needs of the specific homeless veteran population proposed to be served in the specified area or community. Ratings will be made based on the extent to which applicants demonstrate:

(i) Substantial unmet needs, particularly among the target population living in places not ordinarily meant for human habitation (e.g., streets) and in emergency shelters, based on reliable data from surveys of homeless populations, a Comprehensive Housing Affordability Strategy (CHAS), or other reports or data gathering mechanisms that directly support claims made;

(ii) An understanding of the homeless population to be served and its unmet housing and supportive service needs.

(5) *Innovative quality of the proposal.* Applicants who have indicated in their application that they are applying under the innovative supportive housing component must receive points under this criteria to be eligible for award. VA will award up to 50 points based on the innovative quality of the proposal, when compared to other applications and projects; in terms of:

(i) Helping homeless veterans or homeless veterans with disabilities to be served to reach residential stability, increase their skill level and/or income and increase the influence they have over decisions that affect their lives; and

(ii) A clear link between the innovation(s) and its proposed effect(s); and

(iii) Its ability to be used as a model for other projects.

(6) *Leveraging.* VA will award up to 50 points based on the extent to which resources from other public and private sources, including cash and the value of third party contributions, have been committed to support the project at the time of application. *Note:* Any applicant who wishes to receive points under this criterion must submit documentation of leveraged resources which meets the requirements stated in the application. This is optional; applicants who cannot, or choose not to, provide firm documentation of resources as part of the application will forego any points for leveraging.

(7) *Cost-effectiveness.* VA will award up to 100 points for cost-effectiveness. Projects will be rated based on the cost and number of new supportive housing beds made available or the cost, amount and types of supportive services made available, when compared to other transitional housing and supportive services projects, and when adjusted for high-cost areas. Cost-effectiveness may include using excess government properties (local, State, Federal), as well as demonstrating site control at the time of application.

(8) *Coordination with other programs.* VA will award up to 200 points based on the extent to which applicants demonstrate that they have coordinated with Federal, State, local, private and other entities serving homeless persons in the planning and operation of the project. Such entities may include shelter transitional housing, health care, or social service providers; providers funded through Federal initiatives; local planning coalitions or provider associations; or other programs relevant to the local community. Applicants are required to demonstrate that they have coordinated with the VA medical care facility of jurisdiction and VA Regional Offices of jurisdiction in their area. Higher points will be given to those applicants who can demonstrate that:

(i) They are part of an ongoing community-wide planning process which is

designed to share information on available resources and reduce duplication among programs that serve homeless veterans;

(ii) They have consulted directly with other providers regarding coordination of services for project participants. VA will award up to 50 points of the 200 points for this criterion based on the extent to which commitments to provide supportive services are available at the time of application. Applicants who wish to receive points under this optional criterion must submit documentation of supportive service resources.

(Paperwork requirements were approved by the Office of Management and Budget under control number 2900–0554.)

(Authority: 38 U.S.C. 501, 7721, note)

[62 FR 6122, Feb. 11, 1997]

### § 17.712 Selecting applications.

(a) *General.* The highest-ranked applications will be conditionally selected in accordance with their ranked order, as determined under § 17.711 of this part. Each will be requested, as necessary, to provide additional project information, as described in § 17.713 of this part as a prerequisite to a grant from VA.

(b) *Ties between applicants.* In the event of a tie between applicants, VA will use the selecting criterion in § 17.711(d)(4) of this part, need for the type of project proposed in the area to be served, to determine which application should be selected for potential funding.

(c) *Procedural error.* If an application would have been selected but for a procedural error committed by VA, VA will select that application for potential funding when sufficient funds become available if there is no material change in the information that resulted in its selection. A new application will not be required for this purpose.

(Paperwork requirements were approved by the Office of Management and Budget under control number 2900–0554.)

(Authority: 38 U.S.C. 501, 7721, note)

[62 FR 6123, Feb. 11, 1997]

### § 17.713 Obtaining additional information and awarding grants.

(a) *Additional information.* Applicants who have been conditionally selected will be requested by VA to submit additional project information, as described in the second submission of the application, which may include:

(1) Documentation to show that the project is feasible.

(2) Documentation showing the sources of funding for the project and firm financing commitments for the matching requirements described in § 17.706 of this part.

(3) Documentation showing site control, as described in § 17.731 of this part.

(4) Information necessary for VA to ensure compliance with the provisions of the National Environmental Policy Act of 1969 (42 U.S.C. 4321, *et seq.*), as described in § 17.714 of this part.

(5) *A site survey performed by a licensed land surveyor.* A description of the site shall be submitted noting the general characteristics of the site. This should include soil reports and specifications, easements, main roadway approaches, surrounding land uses, availability of electricity, water and sewer lines, and orientation. The description should also include a map locating the existing and/or new buildings, major roads, and public services in the geographic area. Additional site plans should show all site work including property lines, existing and new topography, building locations, utility data, and proposed grades, roads, parking areas, walks, landscaping, and site amenities.

(6) *Design development (35 percent) drawings.* (i) The applicant shall provide to VA one set of sepias and two sets of prints, rolled individually per set, to expedite the review process. The drawing shall indicate the designation of all spaces, size of the areas and rooms, and indicate in outline the fixed and moveable equipment and furniture. The drawings shall be drawn at ⅛″ or ¼″ scale. Bedroom and toilet layouts, showing clearances and Uniform Federal Accessibility Standards requirements, should be shown at ¼″ scale. The total floor and room areas shall be shown in the drawings. The drawings shall include:

(A) A plan of any proposed demolition work;

(B) A plan of each floor. For renovation, the existing conditions and extent of new work should be clearly delineated;

(C) Elevations;

(D) Sections and typical details;

(E) Roof plan;

(F) Fire protection plans; and

(G) Technical engineering plans, including structural, mechanical, plumbing, and electrical drawings.

(ii) If the project involves acquisition, remodeling, or renovation, the applicant should include the current as-built site plan, floor plans and building sections which show the present status of the building and a description of the building's current use and type of construction.

(7) *Design development outline specifications.* The applicant shall provide eight copies of outline specifications which shall include a general description of the project, site, architectural, structural, electrical and mechanical systems such as elevators, air conditioning, heating, plumbing, lighting, power, and interior finishes (floor coverings, acoustical material, and wall and ceiling finishes).

(8) *Design development cost estimates.* The applicant shall provide three copies of cost estimates showing the estimated cost of the buildings or structures to be acquired or constructed in the project. Cost estimates should list the cost of construction, contract contingency, fixed equipment not included in the contract, movable equipment, architect's fees and construction supervision and inspection.

(9) *A design development conference.* After VA reviews design development documents, a design development conference may be recommended in order to provide applicants and their architects an opportunity to learn VA procedures and requirements for the project and to discuss VA review comments.

(10) Such other documentation as specified by VA in writing to the applicant that confirms or clarifies information provided in the application.

(b) *Receipt of additional information.* The required additional information must be received in acceptable form within the time frame established by VA in a notice of fund availability published in the FEDERAL REGISTER. VA reserves the right to remove any proposed project from further consideration for grant assistance if the required additional project information is not received in acceptable form by the established deadline.

(c) *Grant award.* Following receipt of the additional information in acceptable form (and, where applicable, provided that the environmental review described in §17.714 of this part indicates that the proposed project is environmentally acceptable to VA), to the extent funds are available VA will approve the application and send a grant agreement for execution to the applicant.

(Paperwork requirements were approved by the Office of Management and Budget under control number 2900–0554.)

(Authority: 38 U.S.C. 501, 7721, note)

[62 FR 6123, Feb. 11, 1997]

### §17.714 Environmental review requirements.

(a) *General.* Project selection is subject to completion of an environmental review of the proposed site, and the project may be modified or the site rejected as a result of that review. The environmental effects must be assessed in accordance with the requirements of the National Environmental Policy Act of 1969 (NEPA) (42 U.S.C. 4321, *et seq.*) as implemented pursuant to the Council on Environmental Quality's applicable regulations (40 CFR parts 1500–1508) and VA's applicable implementing regulations (38 CFR part 26).

(b) *Responsibility for review.* (1) VA will perform the environmental review, in accordance with part 26 of this title, for conditionally selected applications received directly from private nonprofit organizations and governmental entities with special or limited purpose powers. VA is not permitted to approve such applications prior to its completion of this review. Because of time constraints, any applications subject to environmental review by VA that requires an Environmental Impact Statement (EIS) (generally, an application that VA determines would result in a major Federal action significantly

affecting the quality of the human environment in accordance with the environmental assessment procedures at 38 CFR part 26) will not be eligible for assistance under this part.

(2) Applicants that are States, metropolitan cities, urban counties, Indian tribes, or other governmental entities with general purpose powers shall include environmental documentation for the project submitting information establishing a Categorical Exclusion (CE), a proposed Environmental Assessment (EA), or a proposed Environmental Impact Statement (EIS). The environmental documentation will require approval by VA before final award of a construction or acquisition grant under this part. (See 38 CFR 26.6 for compliance requirements.) If the proposed actions involving construction or acquisition do not individually or cumulatively have a significant effect on the human environment, the applicant shall submit a letter noting a CE. If construction outside the walls of an existing structure will involve more than 75,000 gross square feet (GSF), the application shall include an EA to determine if an EIS is necessary for compliance with section 102(2)(c) of the National Environmental Policy Act 1969. When the application submission requires an EA, the State shall briefly describe the possible beneficial and/or harmful effect which the project may have on the following impact categories:

(i) Transportation;

(ii) Air quality;

(iii) Noise;

(iv) Solid waste;

(v) Utilities;

(vi) Geology (soils/hydrology/flood plains);

(vii) Water quality;

(viii) Land use;

(ix) Vegetation, wildlife, aquatic, and ecology/wetlands;

(x) Economic activities;

(xi) Cultural resources;

(xii) Aesthetics;

(xiii) Residential population;

(xiv) Community services and facilities;

(xv) Community plans and projects; and

(xvi) Other.

(3) If an adverse environmental impact is anticipated, the action to be taken to minimize the impact should be explained in the EA. An entity covered by this section that believes that it does not have the legal capacity to carry out the responsibilities required by 38 CFR part 26 should contact the VA Homeless Providers Grant and Per Diem Program, Mental Health and Behavioral Sciences Service (111C), U.S. Department of Veterans Affairs, 810 Vermont Avenue NW., Washington, DC 20420, for further instructions. Determinations of legal capacity will be made on a case-by-case basis.

(Paperwork requirements were approved by the Office of Management and Budget under control number 2900–0554.)

(Authority: 38 U.S.C. 501, 7721, note)

[62 FR 6124, Feb. 11, 1997]

### § 17.715 Aid for supportive services and supportive housing.

(a) *Per diem payments.* Aid in the form of per diem payments may be paid to an entity meeting the requirements of the regulations of this part under the heading ''VA Homeless Providers Grant and Per Diem Program,'' including the specific criteria of § 17.716 of this part, if:

(1) VA referred the homeless veteran to a recipient of a grant under this part (or entity eligible for such a grant as described in § 17.716 of this part); or

(2) VA authorized the provision of supportive services or supportive housing for the homeless veteran.

(b) *In-kind assistance.* In lieu of per diem payments under this section, VA may, with approval of the grant recipient (or entity eligible for such a grant as described in § 17.716 of this part), provide in-kind assistance through the services of VA employees and the use of other VA resources, to a grant recipient (or entity eligible for such a grant as described in § 17.716 of this part).

(c) *Selection of per diem applicants.* In awarding per diem assistance, applications from grant recipients and nongrant recipients will be reviewed and ranked separately. Funds will first be awarded to grant recipients who request such assistance. If funds are still available for nongrant recipients, VA

will announce funding through a Notice of Funding Availability (NOFA) process as described in §17.708 of this part. VA will not award per diem payments when doing so would decrease funding to those entities already receiving such payments. For both grant recipients and non-grant recipients, eligibility will be determined by the criteria described in §17.716 of this part, and applications will be ranked according to scores achieved on the portions of the application described in §17.716(b)(4) of this part. Applicants must score a minimum of 500 points on these portions to be eligible for per diem. Those applications that meet the eligibility criteria will be conditionally selected for per diem assistance. Funds will be allocated to the highest-ranked, conditionally selected applicants in descending order until funds are expended. Payments will be contingent upon meeting the requirements of a site inspection conducted by VA pursuant to §17.721 of this part.

(d) *Continued receipt of per diem assistance.* (1) Continued receipt of per diem assistance for both grant recipients and nongrant recipients will be contingent upon maintaining the program for which per diem is provided so that it would score at least the required minimum 500 points as described in §17.716(b)(4) of this part on the application. VA will ensure compliance by conducting inspections as described in §17.721 of this part.

(2) Where the recipient fails to comply with paragraph (d)(1) of this section, VA will issue a notice of the Department's intent to discontinue per diem payments. The recipient will then have 30 days to submit documentation demonstrating why payments should not be terminated. After review of any such documentation, VA will issue a final decision on termination of per diem payment.

(3) Continued payment is subject to availability of funds. When necessary due to funding limitations, VA will, in proportion to the decrease in funding available, decrease the per diem payment for each authorized veteran.

(Authority: 38 U.S.C. 501, 7721, note)

[62 FR 6125, Feb. 11, 1997]

### §17.716 Eligibility to receive per diem payments.

An entity must be formally recognized by VA as eligible to receive per diem payments under this section before per diem payments can be made for the care of homeless veterans, except that per diem payments may be made on behalf of a veteran up to three days prior to this recognition.

(a) A grant recipient will be eligible if it receives the minimum score as described in paragraph (b)(4) of this section.

(b) A nongrant recipient will be eligible if it is an entity eligible to receive a grant, which for the purposes of this section means:

(1) At least 75 percent of persons who are receiving supportive services or supportive housing from the entity are veterans who may be included in computation of the amount of aid payable from VA;

(2) The supportive services or supportive housing program for which per diem payments is requested was established after November 10, 1992;

(3) The entity is a public or nonprofit private entity; and

(4) The entity score at least 500 cumulative points on the following sections of the Grant/Per Diem application: Quality (1); Targeting (2); Ability (3); Description of Need (4); and Coordination with Other Programs (8). These sections correspond to the selection criteria of §17.711(c) of this part.

(c) For grant recipients, only those programs that provide supportive services or supportive housing (or the portions thereof) created with grant funds will be considered for per diem assistance. For nongrant recipients, only those portions of the supportive services or supportive housing described in the application will be considered for per diem assistance.

(Authority: 38 U.S.C. 501, 7721, note)

[62 FR 6125, Feb. 11, 1997]

### §17.717 Request for recognition of eligibility.

(a) Requests for recognition of eligibility may be addressed to the VA Homeless Providers Grant and Per

Diem Programs, Mental Health Strategic Healthcare Group (116E), U.S. Department of Veterans Affairs, 810 Vermont Avenue NW., Washington, DC 20420.

(b) For nongrant recipients, the receipt of application for per diem will constitute the request for recognition of eligibility. Grant recipients seeking per diem assistance will indicate this request on the application. Grant recipients are not required to complete a separate application for per diem assistance. VA will review those portions of the grant application that pertain to per diem. Those entities already receiving a grant must submit a request for recognition to initiate the scoring of their application for per diem payments.

(Authority: 38 U.S.C. 501, 7721, note)

[62 FR 6125, Feb. 11, 1997]

### § 17.718 Approval of annexes and new facilities.

Separate applications for recognition must be filed for any annex, branch, enlargement, expansion, or relocation of the site of service provision of an eligible entity's facility which is not on the same or contiguous grounds on which the parent facility is located. When an eligible entity establishes sites which have not been inspected and approved by VA, a request for separate approval of such sites must be made. The prohibitions in § 17.720 of this part are also applicable to applications for aid on behalf of any veterans cared for in a new annex, branch or enlarged, expanded or relocated facility.

(Authority: 38 U.S.C. 501, 7721, note)

[62 FR 6125, Feb. 11, 1997]

### § 17.719 Amount of aid payable.

The per diem amount payable for supportive housing is the current VA State Home Program per diem rate for domiciliary care as set forth in 38 U.S.C. 1741. The per diem amount payable for supportive services, not provided in conjunction with supportive housing, is $1.10 for each half-hour during which supportive services are provided, up to $17.60 per day. These rates will be paid provided, however, the per diem amount for supportive housing or supportive services (not provided in conjunction with supportive housing) does not exceed one-half of the cost to the per diem recipient of providing the services. Also, provided further, per diem payment of supportive housing and supportive services may be lessened because of budget restriction as described in § 17.715(d)(3) of this part. Per diem payments may not be paid for a veteran for both supportive housing and supportive services (not in conjunction with supportive housing).

(Authority: 38 U.S.C. 501, 7721, note)

[62 FR 6126, Feb. 11, 1997]

### § 17.720 Approval of eligibility.

(a) *Eligibility determinations.* A grant recipient (or entity eligible for such a grant as described in § 17.716 of this part) will receive per diem payments or in-kind assistance from VA only for the care of veterans whose separate eligibility has been determined by VA, and only where VA has referred the veteran under § 17.715(a)(1) or has authorized the provision of supportive housing or supportive services under § 17.715(a)(2) of this part. A veteran does not have to be eligible for VA medical care in order for the Department to make per diem payments for that veteran.

(1) VA shall determine the eligibility of each veteran referred to a grant recipient (or entity eligible for such a grant as described in § 17.716 of this part) prior to making such referral.

(2) To obtain such determination for veterans not referred by VA, the grant recipient (or entity eligible for such a grant as described in § 17.716 of this part) will complete a VA application for medical benefits for each veteran and submit it to the VA medical care facility office of jurisdiction for determination of eligibility.

(b) *Retroactive payments.* Per diem payments may be paid retroactively for services provided not more than three days before VA approval is given where VA authorized the provision of services pursuant to § 17.715(a)(2).

[59 FR 28265, June 1, 1994, as amended at 62 FR 6126, Feb. 11, 1997]

### § 17.721 Inspections.

The Secretary may inspect any facility of an entity eligible for per diem

payments under this section at such times as are deemed necessary. Such inspections shall be concerned with the physical plant; records relating to admissions, discharges and occupancy; fiscal records; and all other areas of interest necessary to a determination of compliance with applicable laws and regulations relating to the payment of Federal aid. The authority to inspect carries with it no authority over the management or control of any entity eligible for per diem payments under this section.

### § 17.722 Prerequisite for payment of aid.

No aid may be paid to eligible entities unless they meet the requirement and standards described in §§ 17.724 through 17.726 of this part.

### § 17.723 Audit of recipients of aid.

(a) *State and local government entities.* State, local and Indian tribal governments that receive $25,000 or more in assistance under this part shall have an audit made in accordance with the requirements of 38 CFR part 41.

(b) *Nonprofit entities.* Nonprofit entities receiving assistance under this part shall be subject to the audit requirements contained in OMB Circular A–133.

### § 17.724 General operation.

(a) *State and local requirements.* Each recipient of assistance under this part must provide housing or services that are in compliance with all applicable State and local housing codes, licensing requirements, fire and safety requirements, and any other requirements in the jurisdiction in which the project is located regarding the condition of the structure and the operation of the housing or services.

(b) *Habitability standards.* Except for such variations as are proposed by the recipient that would not affect compliance with paragraph (a) of this section and are approved by VA, supportive housing must meet the following requirements:

(1) *Structure and materials.* The structures must be structurally sound so as not to pose any threat to the health and safety of the occupants and so as to protect the residents from the elements.

(2) *Access.* Entry and exit locations to the structure must be capable of being utilized without unauthorized use of other private properties, and must provide alternate means of egress in case of fire. Buildings constructed or altered with Federal assistance must also be accessible to the disabled, as required by § 502 of the Americans with Disabilities Act, referred to as the Architectural Barriers Act. Waiver of the standards of the Architectural Barriers Act requires approval of the Administrator of the General Services Administration.

(i) The Architectural Barriers Act requires that Federal and Federally-assisted buildings, the intended use for which either will require that such building be accessible to the public, or may result in the employment or residence therein of physically handicapped persons, be accessible to the disabled. This requirement applies to buildings to be constructed or altered by or on behalf of the United States, and to buildings to be leased in whole or in part by the United States (42 U.S.C. 4151).

(ii) Accessibility guidelines for buildings and facilities are set forth in 36 CFR part 1191.

(3) *Space and security*. Each resident must be afforded appropriate space and security for themselves and their belongings. Each resident must be provided an acceptable place to sleep that is in compliance with local codes and regulations.

(4) *Interior air quality*. Every room or space must be provided with natural or mechanical ventilation. Structures must be free of pollutants in the air at levels that threaten the health of residents.

(5) *Water supply*. The water supply must be free from contamination.

(6) *Sanitary facilities.* Residents must have access to sufficient sanitary facilities that are in proper operating condition, may be used in privacy, and are adequate for personal cleanliness and the disposal of human waste.

(7) *Thermal environment.* The housing must have adequate heating and/or cooling facilities in proper operating condition.

(8) *Illumination and electricity*. The housing must have adequate natural or artificial illumination to permit normal indoor activities and to support the health and safety of residents. Sufficient electrical sources must be provided to permit use of essential electrical appliances while assuring safety from fire.

(9) *Food preparation and refuse disposal*. All food preparation areas must contain suitable space and equipment to store, prepare, and serve food in a sanitary manner.

(10) *Sanitary condition*. The housing and any equipment must be maintained in a sanitary manner.

(c) *Meals*. Each recipient of assistance under this part who provides supportive housing for homeless veterans with disabilities must provide meals or meal preparation facilities for residents.

(d) *Ongoing assessment of supportive services*. Each recipient of assistance under this part must conduct an ongoing assessment of the supportive services required by the residents of the project and the availability of such services, and make adjustments as appropriate.

(e) *Residential supervision*. Each recipient of assistance under this part must provide residential supervision necessary to facilitate the adequate provision of supportive services to the residents of the housing throughout the term of the commitment to operate supportive housing. Residential supervision may include the employment or volunteer services of a full- or part-time residential supervisor with sufficient knowledge to provide or to supervise the provision of supportive services to the residents.

(f) *Participation of homeless veterans*. (1) Each recipient of assistance under this part must provide for the consultation and participation of not less than one homeless veteran or formerly homeless veteran on the board of directors or an equivalent policymaking entity of the recipient, to the extent that such entity considers and makes policies and decisions regarding any project, supportive services, or assistance provided under this part. This requirement may be waived if an applicant, despite a good faith effort to comply, is unable to meet it and presents a plan, subject to VA approval, to otherwise consult with homeless or formerly homeless veterans in considering and making such policies and decisions.

(2) Each recipient of assistance under this part must, to the maximum extent practicable, involve homeless veterans and families, through employment, volunteer services, or otherwise, in constructing, rehabilitating, maintaining, and operating the project and in providing supportive services for the project. Programs that do not involve homeless or formerly homeless veterans in such capacities may become ineligible to receive per diem payments. This requirement is waived if a recipient is unable to meet it and presents an explanation for VA approval

(g) *Accounting systems*. Each recipient shall establish procedures for fiscal control and fund accounting to ensure proper disbursement and accounting of assistance received under this part.

(h) *Confidentiality*. (1) Each recipient that provides family violence prevention or treatment services must develop and implement procedures to ensure:

(i) The confidentiality of records pertaining to any individual provided services; and

(ii) That the address or location of any project assisted will not be made public by the recipient and its staff, except with written authorization of the person or persons responsible for the operation of the project.

(2) Each recipient of assistance under this part must maintain the confidentiality of records kept on homeless veterans receiving services.

(i) *Limitation of stay in transitional housing*. A homeless veteran may remain in transitional housing for a period longer than 24 months, if permanent housing for the veteran has not been located or if the veteran requires additional time to prepare for independent living. However, VA may discontinue assistance for a transitional housing project if more than half of the homeless veterans remain in that project longer than 24 months.

(j) *Outpatient health services*. VA may disapprove use of outpatient health services provided through the recipient

if VA determines that such services are of unacceptable quality. VA will not pay per diems for veterans who receive services from providers who VA has found to be of unacceptable quality.

(k) *Service center requirements.* A service center for homeless veterans shall provide services to homeless veterans for a minimum of 40 hours per week over a minimum of five days per week, as well as on an as-needed, unscheduled basis. In addition:

(1) Space in a service center shall be made available as mutually agreeable for use by VA staff and other appropriate agencies and organizations to assist homeless veterans;

(2) A service center shall be equipped to provide, or assist in providing, health care, mental health services, hygiene facilities, benefits and employment counseling, meals, and transportation assistance;

(3) A service center shall provide other services as VA determines necessary based on the need for services otherwise not available in the geographic area;

(4) A service center may be equipped and staffed to provide, or to assist in providing, job training and job placement services (including job readiness, job counseling, and literacy and skills training), as well as any outreach and case management services that may be necessary to meet the requirements of this paragraph.

### § 17.725 Outreach activities.

Recipients must use their best efforts to ensure that eligible hard-to-reach persons are served in the facility funded under this part. Recipients are expected to make sustained efforts to engage eligible persons so that they may be brought into the program. Outreach should be directed primarily toward eligible persons who have a nighttime residence that is an emergency shelter or a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings (*e.g.,* persons living in cars, streets and parks).

### § 17.726 Resident rent.

(a) *Calculation of resident rent.* Each resident of supportive housing may be required to pay as rent an amount determined by the recipient which may not exceed the highest of:

(1) 30 percent of the resident's monthly adjusted income (adjustment factors include the number of relatives in the family residing with the veteran, medical expenses, and child care expenses);

(2) 10 percent of his or her family's monthly income; or

(3) If the family is receiving payments for welfare assistance from a public agency and a part of the payments, adjusted in accordance with the family's actual housing costs, is specifically designated by the agency to meet the family's housing costs, the portion of the payments that is designated.

(b) *Use of rent.* Resident rent may be used in the operation of the project or may be reserved, in whole or in part, to assist residents of transitional housing in moving to permanent housing.

(c) *Fees.* In addition to resident rent, recipients may charge residents reasonable fees for services not paid with VA per diem funds or provided to the service provider by in-kind assistance through the services of VA employees and the use of other VA resources.

### § 17.727 Grant agreement.

(a) *General.* The duty to provide supportive housing or supportive services, or to establish a service center in accordance with the requirements of this part will be incorporated in a grant agreement executed by VA and the recipient.

(b) *Enforcement.* VA will enforce the obligations in the grant agreement through such action as may be appropriate, including repayment of funds that have already been disbursed to the recipient.

### § 17.728 Program changes.

(a) *VA approval.* (1) A recipient may not make any significant changes to an approved program without prior VA approval. Significant changes include, but are not limited to, a change in the recipient, a change in the project site, additions or deletions in the types of activities listed in § 17.702 of this part approved for the program, certain shifts of funds from one approved type of activity to another, and a change in

the category of participants to be served.

(i) Recipients of grants exceeding $100,000 for nonconstruction projects who are State or local governments must receive prior VA approval for cumulative transfers among direct cost categories which exceed or are expected to exceed ten percent of the current total approved budget.

(ii) Recipients of grants for projects involving both construction and nonconstruction who are State or local governments must receive prior VA approval for any budget revision which would transfer funds between nonconstruction and construction categories.

(iii) Recipients of grants exceeding $100,000 who are nonprofit entities must receive prior VA approval for cumulative transfers among direct cost categories or programs, functions and activities which exceed or are expected to exceed ten percent of the total budget as last approved by VA.

(2) Approval for changes is contingent upon the application ranking remaining high enough after the approved change to have been competitively selected for funding in the year the application was selected.

(b) *Documentation of other changes.* Any changes to an approved program that do not require prior VA approval must be fully documented in the recipient's records.

### § 17.729 Obligation and deobligation of funds.

(a) *Obligation of funds.* When VA and the applicant execute a grant agreement, funds are obligated to cover the amount of the approved assistance under §§ 17.702 through 17.707 of this part. The recipient will be expected to carry out the supportive housing or supportive services activities as proposed in the application.

(b) *Increases.* After the initial obligation of funds, VA will not make revisions to increase the amount obligated.

(c) *Deobligation.* (1) VA may deobligate all or parts of grants awarded under this part:

(i) If the actual total cost of acquisition, rehabilitation, acquisition and rehabilitation, or new construction of facilities, or the cost of procurement of a van, is less than the total cost anticipated in the application, or

(ii) Where a recipient materially fails to comply with the terms and conditions of an award under this part.

(2) The grant agreement may set forth in detail other circumstances under which funds may be deobligated, and other sanctions may be imposed. Such sanctions may include, among other remedies: temporarily withholding cash payments pending correction of a deficiency, denying the use of grant or matching funds for all or part of the cost of an activity not in compliance, wholly or partly suspending an award, and withholding further awards to the recipient.

(3) Where a recipient has no control over causes for delays in implementing a project, any delays due to causes beyond a recipient's control may, with VA approval, suspend the running of any period in which the recipient must implement a program or risk deobligation of funds or other VA remedies.

(4) VA may:

(i) Readvertise in a notice of fund availability under § 17.708 of this part, the availability of funds awarded that were deobligated in the same fiscal year as obligated; or

(ii) Award funds deobligated in the same fiscal year as obligated to applications previously submitted in response to the most recently published notice of fund availability, and in accordance with §§ 17.708 through 17.714 of this part; or

(iii) If legally authorized, award amounts deobligated in a fiscal year later than the fiscal year in which they were obligated to applications previously submitted in response to the most recently published notice of fund availability, and in accordance with §§ 17.708 through 17.714 of this part.

### § 17.730 Displacement, relocation, and acquisition.

(a) *Minimizing displacement.* Consistent with other goals and objectives of this part, recipients must take all reasonable steps to minimize the displacement of persons (families, individuals, businesses, nonprofit organizations, and farms) as a result of supportive housing, supportive services, or

service centers assisted under this part. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in the purchases.

(b) *Relocation assistance for displaced persons.* A displaced person must be provided relocation assistance at the levels described in, and in accordance with, the requirements of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (URA) (42 U.S.C. 4601–4655).

(c) *Certification.* The recipient must certify that it will comply with the URA, and must ensure such compliance notwithstanding any third party's contractual obligation to the recipient to comply with these provisions.

(d) *Cost of relocation assistance.* The cost of required relocation assistance is not an eligible project cost, in that such costs are operational costs. Such costs must be paid for with local public funds or funds available from other sources.

(e) *Definition of initiation of negotiations.* For purposes of determining the formula for computing the replacement housing assistance to be provided to a residential tenant displaced as a direct result of privately undertaken rehabilitation, demolition, or acquisition of the real property, the term ''initiation of negotiations'' means the execution of the agreement between the recipient and VA, or selection of the project site, if later.

### § 17.731 Site control.

(a) *Site control.* (1) Where grant funds will be used for acquisition, rehabilitation, or new construction to provide supportive housing or supportive services, or to establish service centers, except where an applicant will provide services at sites not operated by the applicant, an applicant must demonstrate site control (*e.g.,* through a deed, capital lease, executed contract of sale) before VA will execute a grant agreement. A lease other than a capital lease does not demonstrate site control except for a VA lease as described in § 17.700(a) of this part.

(2) If such site control is not demonstrated within one year after initial notification of the award of assistance under this part, the grant will be deobligated as provided in paragraph (c) of this section.

(b) *Site change.* (1) A recipient may obtain ownership or control of a suitable site different from the one specified in its application. Retention of an assistance award is subject to the new site's meeting all requirements for suitable sites under this part.

(2) If the acquisition, rehabilitation, acquisition and rehabilitation, or new construction costs of the substitute site are greater than the amount of the grant awarded for the site specified in the application, the recipient must provide for all additional costs. If the recipient is unable to demonstrate to VA that it is able to provide for the difference in costs, VA may deobligate the award of assistance.

(c) *Failure to obtain site control within one year.* VA will deobligate any award for assistance under this part or pursue other remedies described in § 17.729(c) of this part if the recipient is not in control of a suitable site before the expiration of one year after initial notification of an award.

[59 FR 28265, June 1, 1994, as amended at 60 FR 10504, Feb. 27, 1995]

## TRANSITIONAL HOUSING LOAN PROGRAM

SOURCE: 59 FR 49579, Sept. 29, 1994, unless otherwise noted.

### § 17.800 Purpose.

The purpose of the Transitional Housing Loan Program regulations is to establish application provisions and selection criteria for loans to non-profit organizations for use in initial start-up costs for transitional housing for veterans who are in (or have recently been in) a program for the treatment of substance abuse. This program is intended to increase the amount of transitional housing available for such veterans who need a period of supportive housing to encourage sobriety maintenance and reestablishment of social and community relationships.

### § 17.801 Definitions.

(a) *Applicant:* A non-profit organization making application for a loan under this program.

(b) *Non-profit organization:* A secular or religious organization, no part of

the net earnings of which may inure to the benefit of any member, founder, contributor, or individual. The organization must include a voluntary board and must either maintain or designate an entity to maintain an accounting system which is operated in accordance with generally accepted accounting principles. If not named in, or approved under Title 38 U.S.C. (United States Code), Section 5902, a non-profit organization must provide VA with documentation which demonstrates approval as a non-profit organization under Internal Revenue Code, Section 501.c(3).

(c) *Recipient:* A non-profit organization which has received a loan from VA under this program.

(d) *Veteran:* A person who served in the active military, naval, or air service, and who was discharged or released therefrom under conditions other than dishonorable.

(Authority: Sec. 8 of Pub. L. 102–54, 105 Stat 271, 38 U.S.C. 501)

### § 17.802 Application provisions.

(a) To obtain a loan under these Transitional Housing Loan Program regulations, an application must be submitted by the applicant in the form prescribed by VA in the application package. The completed application package must be submitted to the Deputy Associate Director for Psychiatric Rehabilitation Services, (302/111C), VA Medical Center, 100 Emancipation Drive, Hampton, VA 23667. An application package may be obtained by writing to the proceeding address or telephoning (804) 722–9961 x3628. (This is not a toll-free number)

(b) The application package includes exhibits to be prepared and submitted, including:

(1) Information concerning the applicant's income, assets, liabilities and credit history,

(2) Information for VA to verify the applicant's financial information,

(3) Identification of the official(s) authorized to make financial transactions on behalf of the applicant,

(4) Information concerning:

(i) The history, purpose and composition of the applicant,

(ii) The applicant's involvement with recovering substance abusers, including:

(A) Type of services provided,

(B) Number of persons served,

(C) Dates during which each type of service was provided,

(D) Names of at least two references of government or community groups whom the organization has worked with in assisting substance abusers,

(iii) The applicant's plan for the provision of transitional housing to veterans including:

(A) Means of identifying and screening potential residents,

(B) Number of occupants intended to live in the residence for which the loan assistance is requested,

(C) Residence operating policies addressing structure for democratic self-government, expulsion policies for non-payment, alcohol or illegal drug use or disruptive behavior,

(D) Type of technical assistance available to residents in the event of house management problems,

(E) Anticipated cost of maintaining the residence, including rent and utilities,

(F) Anticipated charge, per veteran, for residing in the residence,

(G) Anticipated means of collecting rent and utilities payments from residents,

(H) A description of the housing unit for which the loan is sought to support, including location, type of neighborhood, brief floor plan description, etc., and why this residence was selected for this endeavor.

(iv) The applicant's plans for use of the loan proceeds.

(Authority: Sec. 8 of Pub. L. 102–54, 105 Stat. 271, 38 U.S.C. 501)

### § 17.803 Order of consideration.

Loan applications will be considered on a first-come-first-serve basis, subject to availability of funds for loans and awards will be made on a first-come-first-serve basis to applicants who meet the criteria for receiving a loan. If no funds are available for loans, applications will be retained in the order of receipt for consideration as funds become available.

(Authority: Sec. 8 of Pub. L. 102–54, 105 Stat. 271, 38 U.S.C. 501)

### § 17.804 Loan approval criteria.

Upon consideration of the application package, loan approval will be based on the following:

(a) Favorable financial history and status,

(1) A minimum of a two-year credit history,

(2) No open liens, judgments, and no unpaid collection accounts,

(3) No more than two instances where payments were ever delinquent beyond 60 days,

(4) Net ratio: (monthly expenses divided by monthly cash flow) that does not exceed 40%,

(5) Gross ratio: (total indebtedness divided by gross annual cash flow) that does not exceed 35%,

(6) At least two favorable credit references,

(b) Demonstrated ability to successfully address the needs of substance abusers as determined by a minimum of one year of successful experience in providing services, such as, provision of housing, vocational training, structured job seeking assistance, organized relapse prevention services, or similar activity. Such experience would involve at least twenty-five substance abusers, and would be experience which could be verified by VA inquiries of government or community groups with whom the applicant has worked in providing these services.

(c) An acceptable plan for operating a residence designed to meet the conditions of a loan under this program, which will include:

(1) Measures to ensure that residents are eligible for residency, i.e., are veterans, are in (or have recently been in) a program for the treatment of substance abuse, are financially able to pay their share of costs of maintaining the residence, and agree to abide by house rules and rent/utilities payment provisions,

(2) Adequate rent/utilities collections to cover cost of maintaining the residence,

(3) Policies that ensure democratic self-run government, including expulsion policies, and

(4) Available technical assistance to residents in the event of house management problems.

(d) Selection of a suitable housing unit for use as a transitional residence in a neighborhood with no known illegal drug activity, and with adequate living space for number of veterans planned for residence (at least one large bedroom for every three veterans, at least one bathroom for every four veterans, adequate common space for entire household)

(e) Agreements, signed by an official authorized to bind the recipient, which include:

(1) The loan payment schedule in accordance with the requirements of Pub. L. 102–54, with the interest rate being the same as the rate the VA is charged to borrow these funds from the U.S. Department of Treasury and with a penalty of 4% of the amount due for each failure to pay an installment by the date specified in the loan agreement involved, and

(2) The applicant's intent to use proceeds of loan only to cover initial startup costs associated with the residence, such as security deposit, furnishings, household supplies, and any other initial startup costs.

(Authority: Sec. 8 of Pub. L. 102–54, 105 Stat. 271, 38 U.S.C. 501)

### § 17.805 Additional terms of loans.

In the operation of each residence established with the assistance of the loan, the recipient must agree to the following:

(a) The use of alcohol or any illegal drugs in the residence will be prohibited;

(b) Any resident who violates the prohibition of alcohol or any illegal drugs will be expelled from the residence;

(c) The cost of maintaining the residence, including fees for rent and utilities, will be paid by residents;

(d) The residents will, through a majority vote of the residents, otherwise establish policies governing the conditions of the residence, including the manner in which applications for residence are approved;

(e) The residence will be operated solely as a residence for not less than six veterans.

(Authority: Sec. 8 of Pub. L. 102–54, 105 Stat. 271, 38 U.S.C. 501)

HEALTH CARE FOR A VIETNAM VETERAN'S CHILD WITH SPINA BIFIDA

SOURCE: 62 FR 51284, Sept. 30, 1997, unless otherwise noted.

### § 17.900 Spina bifida—provision of health care.

(a) VA shall provide a Vietnam veteran's child who has been determined under § 3.814 of this title to suffer from spina bifida with such health care as the Secretary determines is needed by the child for the spina bifida or any disability that is associated with such condition. This is not intended to be a comprehensive insurance plan and does not cover health care unrelated to spina bifida.

(b) Health care provided under this section shall be provided directly by VA, by contract with an approved health care provider, or by other arrangement with an approved health care provider. VA may inform spina bifida patients, parents, or guardians that health care may be available at not-for-profit charitable entities.

(Authority: 38 U.S.C. 101(2), 1801–1806)

NOTE TO § 17.900: VA provides payment under this section only for health care relating to spina bifida or a disability that is associated with such condition. VA is the exclusive payer for services paid under this section regardless of any third party insurer, Medicare, Medicaid, health plan, or any other plan or program providing health care coverage. Any third-party insurer, Medicare, Medicaid, health plan, or any other plan or program providing health care coverage would be responsible according to its provisions for payment for health care not relating to spina bifida and not constituting a disability that is associated with such condition (accordingly, in the usual case claims for health care for other than covered services for spina bifida and disabilities associated with spinal bifida would be submitted to an insurer, Medicare, Medicaid, health plan, or other program providing health care coverage).

### § 17.901 Definitions.

For purposes of §§ 17.900 through 17.905—

*Approved health care provider* means a health care provider approved by the Health Care Financing Administration (HCFA), Department of Defense Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA), Joint Commission on Accreditation of Health Care Organizations (JCAHO), or any health care provider approved for providing health care pursuant to a state license or certificate. An entity or individual shall be deemed to be an approved health care provider only when acting within the scope of the approval, license, or certificate.

*Child* means the same as defined at § 3.814(c) of this title.

*Habilitative and rehabilitative care* means such professional counseling, guidance services and treatment programs (other than vocational training under 38 U.S.C. 1804) as are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of a disabled person.

*Health care* means home care, hospital care, nursing home care, outpatient care, preventive care, habilitative and rehabilitative care, case management, and respite care; and includes the training of appropriate members of a child's family or household in the care of the child; and the provision of such pharmaceuticals, supplies (including continence-related supplies such as catheters, pads, and diapers), equipment (including durable medical equipment), devices, appliances, assistive technology, direct transportation costs to and from approved health care providers (including any necessary costs for meals and lodging en route, and accompaniment by an attendant or attendants), and other materials as the Secretary determines necessary.

*Health care provider* means any entity or individual who furnishes health care, including specialized spina bifida clinics, health care plans, insurers, organizations, and institutions.

*Home care* means medical care, habilitative and rehabilitative care, preventive health services, and health-related services furnished to an individual in the individual's home or other place of residence.

*Hospital care* means care and treatment furnished to an individual who has been admitted to a hospital as a patient.

*Nursing home care* means care and treatment furnished to an individual who has been admitted to a nursing home as a resident.

*Outpatient care* means care and treatment, including preventive health services, furnished to an individual other than hospital care or nursing home care.

*Preventive care* means care and treatment furnished to prevent disability or illness, including periodic examinations, immunizations, patient health education, and such other services as the Secretary determines necessary to provide effective and economical preventive health care.

*Respite care* means care furnished on an intermittent basis for a limited period to an individual who resides primarily in a private residence when such care will help the individual continue residing in such private residence.

*Spina bifida* means all forms and manifestations of spina bifida except spina bifida occulta (this includes complications or associated medical conditions which are adjunct to spina bifida according to the scientific literature).

*Vietnam veteran* means the same as defined at §3.814(c) of this title.

(Authority: 38 U.S.C. 101(2), 1801–1806, Pub. L. 105–114)

### §17.902 Preauthorization.

(a) Preauthorization from a preauthorization specialist of the Health Administration Center is required for health care consisting of case management, durable medical equipment, home care, professional counseling, mental health services, respite care, training, substance abuse treatment, dental services, transplantation services, or travel (other than mileage at the General Services Administration rate for privately owned automobiles). This care will be authorized only in those cases where there is a demonstrated medical need. Applications for provision of health care requiring preauthorization shall either be made by telephone at (800) 733–8387, or in writing to Health Administration Center, P.O. Box 65025, Denver, CO 80206–9025. The application shall contain the following:

(1) Name of child,

(2) Child's social security number,

(3) Name of veteran,

(4) Veteran's social security number,

(5) Type of service requested,

(6) Medical justification,

(7) Estimated cost, and

(8) Name, address, and telephone number of provider.

(b) Notwithstanding the provisions of paragraph (a) of this section, preauthorization shall not be required for a condition for which failure to receive immediate treatment poses a serious threat to life or health. Such emergency care should be reported by telephone at (800) 733–8387 to the Health Administration Center, Denver, CO within 72 hours of the emergency.

(Paperwork requirements were approved by the Office of Management and Budget under control number 2900–0577.)

(Authority: 38 U.S.C. 101(2), 1801–1806, Pub. L. 105–114)

### §17.903 Payment.

(a)(1) Payment under this section will be determined utilizing the same payment methodologies as provided for under the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) (see 38 CFR 17.84).

(2) As a condition of payment, the services must have occurred on or after October 1, 1997, and must have occurred on or after the date the child was determined eligible for benefits under §3.814 of this title. Also, as a condition of payment, claims from approved health care providers for health care provided under this section must be filed with the Health Administration Center, P.O. Box 65025, Denver, CO 80206–9025, no later than:

(i) One year after the date of service; or

(ii) In the case of inpatient care, one year after the date of discharge; or

(iii) In the case of retroactive approval for health care, 180 days following beneficiary notification of authorization.

(3) Claims for health care provided under the provisions of §§17.900 through 17.905 shall contain, as appropriate, the information set forth in paragraphs (a)(3)(i) through (a)(3)(v) of this section.

(i) Patient identification information:
(A) Full name,
(B) Address,
(C) Date of birth, and
(D) Social Security number.
(ii) Provider identification information (inpatient and outpatient services):
(A) Full name and address (such as hospital or physician),
(B) Remittance address,
(C) Address where services were rendered,
(D) Individual provider's professional status (M.D., Ph.D., R.N., etc.), and
(E) Provider tax identification number (TIN) or Social Security number.
(iii) Patient treatment information (long-term care or institutional services):
(A) Dates of service (specific and inclusive),
(B) Summary level itemization (by revenue code),
(C) Dates of service for all absences from a hospital or other approved institution during a period for which inpatient benefits are being claimed,
(D) Principal diagnosis established, after study, to be chiefly responsible for causing the patient's hospitalization,
(E) All secondary diagnoses,
(F) All procedures performed,
(G) Discharge status of the patient, and
(H) Institution's Medicare provider number.
(iv) Patient treatment information for all other health care providers and ancillary outpatient services such as durable medical equipment, medical requisites and independent laboratories:
(A) Diagnosis,
(B) Procedure code for each procedure, service or supply for each date of service, and
(C) Individual billed charge for each procedure, service or supply for each date of service.
(v) Prescription drugs and medicines and pharmacy supplies:
(A) Name and address of pharmacy where drug was dispensed,
(B) Name of drug,
(C) Drug Code for drug provided,
(D) Strength,
(E) Quantity,
(F) Date dispensed,
(G) Pharmacy receipt for each drug dispensed (including billed charge), and
(H) Diagnosis.

(b) Health care payment shall be provided in accordance with the provisions of §§ 17.900 through 17.905. However, the following are specifically excluded from payment:
(1) Care as part of a grant study or research program,
(2) Care considered experimental or investigational,
(3) Drugs not approved by the U.S. Food and Drug Administration for commercial marketing,
(4) Services, procedures or supplies for which the beneficiary has no legal obligation to pay, such as services obtained at a health fair,
(5) Services provided outside the scope of the provider's license or certification, and
(6) Services rendered by providers suspended or sanctioned by a Federal agency.

(c) Payments made in accordance with the provisions of §§ 17.900 through 17.905 shall constitute payment in full. Accordingly, the health care provider or agent for the health care provider may not impose any additional charge for any services for which payment is made by VA.

(d) *Explanation of benefits (EOB).* When a claim under the provisions of §§ 17.900 through 17.905 is adjudicated, an EOB will be sent to the beneficiary or guardian and the provider. The EOB provides at a minimum, the following information:
(1) Name and address of recipient,
(2) Description of services and/or supplies provided,
(3) Dates of services or supplies provided,
(4) Amount billed,
(5) Determined allowable amount,
(6) To whom payment, if any, was made, and
(7) Reasons for denial (if applicable).

(Paperwork requirements were approved by the Office of Management and Budget under control number 2900–0577.)

(Authority: 38 U.S.C. 101(2), 1801–1806, Pub. L. 105–114)

### § 17.904 Review and appeal process.

If a health care provider, Vietnam veteran's child or representative disagrees with a determination concerning provision of health care or a health care provider disagrees with a determination concerning payment, the person or entity may request reconsideration. Such request must be submitted in writing within one year of the date of the initial determination to the Chief, Administrative Division, Health Administration Center, P.O. Box 65025, Denver, CO 80206–9025. The request must state why it is concluded that the decision is in error and must include any new and relevant information not previously considered. Any request for reconsideration that does not identify the reason for dispute will be returned to the sender without further consideration. After reviewing the matter, including any relevant supporting documentation, a benefits advisor will issue a written determination (with a statement of findings and reasons) to the person or entity seeking reconsideration that affirms, reverses or modifies the previous decision. If the person or entity seeking reconsideration is still dissatisfied, within 90 days of the date of the decision he or she may make a written request for review by the Director, Health Administration Center, P.O. Box 65025, Denver, CO 80206–9025. The Director will review the claim and any relevant supporting documentation and issue a decision in writing (with a statement of findings and reasons) that affirms, reverses or modifies the previous decision. An appeal under this section would be considered as filed the time it was delivered to the VA or at the time it was released for submission to the VA (for example, this could be evidenced by the postmark, if mailed).

NOTE TO § 17.904: The final decision of the Director will inform the claimant of further appellate rights for an appeal to the Board of Veterans Appeals.

(Paperwork requirements were approved by the Office of Management and Budget under control number 2900–0577.)

(Authority: 38 U.S.C. 101(2), 1801–1806)

### § 17.905 Medical records.

Copies of medical records generated outside VA that relate to activities for which VA is asked to provide payment, and that VA determines are necessary to adjudicate claims under §§ 17.900 through 17.905, must be provided to VA at no cost.

(Authority: 38 U.S.C. 101(2), 1801–1806)